

THE MEDICS' WAR



Albert E. Cowdrey

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UNITED STATES ARMY IN THE KOREAN WAR

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by
Albert E. Cowdrey



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. . . to Those Who Served

Foreword

This is the fourth volume published by the U.S. Army Center of Military History in its United States Army in the Korean War series. Once termed a police action, the Korean War was fought by massed armies on a constricted field of operations. Its battles were as intense as those of any other war this century.

The Medics' War views this conflict from an uncommon angle. It documents the efforts of American Army doctors, nurses, and enlisted medics to save life and repair the damages wrought by wounds and disease. Though the charges of biological warfare made at the time are shown to have no foundation, the disease-ridden environment of wartime Korea aided the side with the best medical care. The real MASH clearly emerges in this study, along with the variety of technical innovations produced by the conflict that have advanced medical science.

The perspective of *The Medics' War* is an enlightening one, showing that the compassionate treatment of both United Nations and enemy wounded preserved human values in the midst of bitter, unforgiving strife. Civilian and military readers alike will gain from it a deeper understanding of the processes, destructive and reconstructive, that together made up the human experience of the Korean War.

Washington, D.C.
24 March 1986

WILLIAM A. STOFFT
Brigadier General, USA
Chief of Military History

The Author

Albert E. Cowdrey was born in New Orleans, Louisiana, and received his education from the schools of that city and from Tulane and Johns Hopkins Universities. He served in the Army as an enlisted man during the years 1957–59. After teaching at Tulane University and at Louisiana State University in New Orleans he entered the government historical programs, working for the Corps of Engineers historical office and, since 1978, for the U.S. Army Center of Military History. His continuing interest in southern history brought him the Herbert Feis Award of the American Historical Association, in 1984, for his book *This Land, This South*. He has written widely on medical and military history, in American and British journals. *The Medics' War* was written while he was chief of the Medical History Branch at the Center of Military History.

Preface

The medical history of war casts light not only upon the suffering of those who fight but upon the dedication of those who save. Though the association between slaying and saving is paradoxical, it exists and helps to shape the nature of modern warfare—and of modern medicine as well.

Often the effort to forestall or to repair war's damages by preventing disease and managing trauma has served to advance medical science. During the past century, conquest of the ancient camp diseases has changed the definition of what is militarily possible. The kind of struggle fought on the Western Front during World War I would have been impossible in times past, when large immobile bodies of troops would have spawned devastating epidemics. In World War II Americans, aided by further medical progress, were able to fight for years in the most varied disease environments. In turn, that struggle introduced to the world a variety of innovations, including the mass production and use of penicillin and DDT. During the same period, improvements in surgery and the introduction of a systematic program to supply whole blood steadily reduced the death rate among the wounded in military hospitals.

In the roster of wars that have contributed to medical progress, the Korean conflict holds a place of importance. Major innovations included the MASH (mobile army surgical hospital); widespread use of the helicopter for medical evacuation; improved forward vascular surgery; and advances in the handling and treatment of neurosurgical injuries. Indeed, modern emergency medicine would be hard to imagine without the pioneer work done on the Korean battlefields. By their courage and skill American medics in Korea were able to save and restore the lives of many soldiers and marines who otherwise would have succumbed to the fighting, the omnipresent diseases, and the harsh field conditions.

While researching and writing *The Medics' War*, I benefited from the support and expertise of many people. The bibliographical essay gives credit to the writers of earlier published works. My thanks are due especially to the archivists and librarians of the Washington area, notably to Hannah M. Zeidlick, Charles Ellsworth, Geraldine K. Judkins, and Mary J. Sawyer of the U.S. Army Center of Military History; to Norman M. Covert at Fort Detrick; to Dorothy Hanks at the National Library of Medicine; and to Victoria S. Washington and Fred W. Pernell at the National Archives and Records Administration. Mr. Pernell, in particular, deserves a campaign ribbon for his unwearied help to myself and later to my editor.

Fellow historians displayed their usual professional generosity, providing perceptive comments on my efforts and constructive suggestions for improve-

ment. John Duffy, now professor emeritus at the University of Maryland, offered valuable guidance in many phases of the writing—notably by allowing me to audit his course in medical history when I first began to study this difficult specialty—and also critically reviewed the manuscript. J. Kenneth MacDonald, historian of the Central Intelligence Agency, made materials available to me from his agency's files. Richard J. Sommers of the U.S. Army Military History Institute, Carlisle Barracks, was most helpful. Robert J. T. Joy, M.D., of the Uniformed Services University of the Health Sciences played a special role in the making of the book. He was a mine of information on the history of military medicine; encouraged me to assemble my notes on germ warfare for an article in the *Journal of the History of Medicine and Allied Sciences*, which he edits; and, as a member of the panel on this book, provided a lengthy and useful critique.

My colleagues at the Center of Military History contributed beyond my ability to offer adequate thanks. Mary C. Gillett placed her formidable scholarly knowledge of medico-military topics at my disposal. The ongoing works of Graham A. Cosmas and Mary Ellen Condon-Rall on the medical history of World War II yielded valuable insights into the immediate background of the Korean struggle. Young Gil Chang—since tragically deceased—saved me from errors not only by his historical insight but also by his grasp of the language and culture of his native land. Billy G. Mossman read the manuscript with a critical eye and offered constructive suggestions. Unfailing encouragement and support came from two successive chiefs of the Histories Division, Col. James W. Dunn and Lt. Col. Richard O. Perry, and from Chief Historian David F. Trask. Stephen E. Everett reviewed for accuracy the material on Army units. Linda M. Cajka skillfully designed the maps, charts, and paperback cover, and also prepared the photographs. Finally, my editor, Joanne M. Brignolo, was extraordinarily diligent both in clearing the knotty language from the text and in amplifying the footnotes to provide maximum information to the critical reader. It is, however, due to all these valued associates and mentors to say that any errors remaining in the book are entirely my own.

War and healing meet in many places, in the field and prison camp, in the hospital and laboratory. I hope that those who study either, or merely enjoy reading about them, will find some matters of interest in the contribution that follows.

Washington, D.C.
24 March 1986

ALBERT E. COWDREY

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The illustration on p. 223 is from the photo collection of the Library of Congress. All other illustrations are from the files of the Department of Defense and the Department of the Army. The author's article, "'Germ Warfare' and Public Health in the Korean Conflict," *Journal of the History of Medicine and Allied Sciences* 39 (April 1984), was used in Chapter 7 with permission of the editor, Robert J. T. Joy, M.D.

THE MEDICS' WAR

PROLOGUE

The Unexpected War

In the rain-soaked predawn darkness of 25 June 1950 the armed forces of Communist North Korea crossed the 38th Parallel, aiming at a quick conquest of the ill-armed and ill-prepared Republic of Korea (ROK). Within three days the capital city of Seoul fell, and refugees thronged the roads leading south. In the United States, which had helped to create and sponsor the South Korean government, news of the attack arrived on the evening of the twenty-fourth (Washington time). For many high officials the first reaction was utter surprise. Maj. Gen. Raymond W. Bliss, the quiet, gentlemanly Yankee then serving as surgeon general of the Army, remarked to his staff that “just a week or so ago G-2 made the statement that we would be alerted perhaps 6 months before any [Communist] invasion and at least 10 days. We had not a moment’s notice regarding Korea.”¹

Since World War II the American military had looked to a general conflict with the Communist powers as the only alternative to peace. No plan existed for a limited war or for partial mobilization. Yet American leaders discovered on the morrow of the invasion that the strategic significance of Korea was as great as when, a generation earlier, Japan, China, and Russia had struggled over the unhappy nation. Its moral significance in a world divided by the Cold War into two armed camps was incalculable. In the week that followed, President Harry S. Truman and his advisers improvised a national policy to resist armed aggression and sought the support of the United Nations (U.N.) for the effort. Without awaiting U.N. action, Washington committed air, naval, and then ground forces to the conflict.²

¹Quoted words from Surgeon General Early Morning Conference Notes (hereinafter cited as SG Conference Notes), 26 Jun 50, Medical Collection, HRB. All manuscript sources given without record group (RG) numbers, unless otherwise stated, are in the U.S. Army Center of Military History (CMH), Washington, D.C.; location within CMH is specified by the following codes: HRB (Historical Records Branch), CHA (Clinical History Activity), SSB (Staff Support Branch), LIB (Library), and HSF (Historian’s source file). Those sources with RG numbers are in the National Archives and Records Administration (NARA), Washington, D.C.; location within NARA is specified by the following codes: MMHB (Modern Military Headquarters Branch); MMFB (Modern Military Field Branch), PAB (Printed Archives Branch), and WNRC (Washington National Records Center).

²Walter G. Hermes, “Survey of Planning for the Mobilization and Deployment of Army Divisions, 1944–1968,” CMH Historical Study, rev. (Washington, D.C., 1968), pp. 1–11, project file 74, SSB; Joseph C. Goulden, *Korea: The Untold Story of the War* (New York: Times Books, 1982), pp. 84–105.

For the Army medics stationed in Japan,³ the first experience of the new war came as they helped to move supplies into Korea and provided medical care for American refugees—diplomats, military advisers, and their families. South Korea's first pleas for assistance on 25 June included many medical items—bandages, iodine, penicillin, and sulfa crystals, among other things. Committed to provide logistical support, the Far East Command (FEC) in Tokyo dispatched on the twenty-seventh the Advance Command and Liaison Group, which consisted of fifteen officers and two enlisted men.

Among the officers was Lt. Col. Everett W. Partin of the Medical Service Corps (MSC) who headed the FEC surgeon's Supply and Fiscal Division. At Suwon, a road junction south of Seoul, Partin met the surgeon general of the ROK Army, who informed him that the enemy had seized all the medical supplies stored in the capital. Partin hastily scribbled the first medical requisition of the war to Capt. Richard M. Stacey, MSC, of the Medical Section, Far East Command:

Dear Stacey:

Rush the items listed by first available air transportation. Ship to TAEJON, mark for 'U.S. DISPENSARY'. We are getting casualties and need the stuff *now*.

(signed) *Everett*

P.S. Tell my wife I got the package. Please rush raincoat.⁴

The requisition, in pencil on thin paper, included requests for splints, thermometers, pajamas, cotton, and bandages.

Meanwhile, the surgeon of the 24th Infantry Division, Maj. Wade F. Heritage, a Medical Corps officer, and the men of the 24th Medical Battalion provided aid to the fifteen hundred Americans evacuated from Korea by air and sea. An officer with the 155th Station Hospital found the dependents "dazed and bewildered, with nothing but the clothes on their backs." At the Osaka Army Hospital a young doctor, newly arrived from the United States, "had his hands full taking care of hysterical mothers, and cranky, weeping babies; and getting together all the baby bottles, diapers and cribs he could find."⁵

³The term *medics* is used in the text as shorthand for "the men and women of the U.S. Army Medical Service." Enlisted medics are identified either by this term or as corpsmen.

⁴Quoted words from Note, Lt Col Everett W. Partin, MSC, Medical Section, USAFIK, to Capt Richard M. Stacey, MSC, Medical Section, FEC, received 28 Jun 50, HSF (Partin-1950), HRB. See also Far East Command (hereinafter cited as FEC), Annual Report of Medical Service Activities, 1950, pp. 8, 12, file 319.1-2 (FEC) Far East-1950, HRB.

⁵First quotation from Interv, Samuel Milner with Lt Col Harry L. Gans, MSC (hereinafter cited as Gans Interv), 29 May 66, p. 2. Second quotation from Interv, Samuel Milner with Col Frank A. Neuman, MC (hereinafter cited as Neuman Interv), 28 May 66, p. 2. Both in AMEDD Oral History files (Gans) and (Neuman), HRB. See also United States Army Forces, Far East, and Eighth United States Army, Rear (hereinafter cited as USAFFE and EUSAR), "Logistics in the Korean Operations," vol. 1, p. 4, Ms no. 8-5.1A AZ, RG 319, MMHB; Surgeon's Section, 24th Infantry Division, Journal, 29-30 Jun 50, 24th Infantry Division War Diary, file 324 (Surg's Journal, 24th Inf Div, 25 Jun-22 Jul 50), Box 3479 (24th Inf Div, Surg, Sig, and Chem Journals, Books 31-33, 25 Jun-22 Jul 50), Entry 429, RG 407, MMFB; 1st End, Maj F. M. Cowman, Assistant Adjutant General, USAFFE, to Chief of Military History, DA, 16 Nov 53, sub: Transmittal of Revised Draft Manuscript . . . , attached to 8086th Army Unit, Military History Detachment, "Evacuation of Refugees



AMERICAN EVACUEES FROM KOREA ARRIVING IN JAPAN

Other Americans appeared among the streams of refugees afoot in Korea. By noon of the twenty-eighth about one hundred had straggled into Suwon, without equipment other than their clothes. A medical officer, 1st Lt. Robert B. Giffin, Jr., had saved his doctor's kit. He set up a dispensary in a small room of a local house and began to treat the injured. The next day airlift planes started to arrive, but the activity at the airstrip provoked strafing and bombing attacks by North Koreans and Americans unloading the planes took several casualties. After the supplies were turned over to the South Koreans for distribution, the planes began to evacuate the wounded.

The invaders were drawing close. On the evening of the thirtieth, with the encirclement of Suwon imminent, the Americans made their way by motor vehicle to Taejon, an important road and rail junction about 75 miles to the south. The South Koreans, having saved the medical supplies that originally were reported lost, moved them to Taejon. Here the Advance Command and Liaison Group remained for the time.⁶

In Washington and Tokyo medical planners began to look over the resources that were available to fight this unexpected war. What they found was a shortage

and Civilians from Seoul, June 1950 and December 1950 to January 1951," Ms no. 8-5.1A AT, RG 319, MMHB.

⁶Far East Command (hereinafter cited as FEC), Report of Essential Technical Medical Data (hereinafter cited as ETMD), July 1950, pp. 19-20, file 350.05 (FEC) 1950, HRB.

of trained men and women, large masses of supplies and a substantial body of experience deriving from World War II, and a group of newly trained physician specialists whose performance in combat had yet to be assessed. The Army Medical Service itself was in many ways a new organization, drastically reorganized and reformed in the five years since the defeat of the Axis. With broad experience in the Far East gained from the occupation of Japan and Korea, the medics faced a new kind of war, one that soon would demand surprising improvisations. But in the early days of the fighting, and indeed throughout the struggle, the experience of World War II and the changes brought by the brief years of peace would affect the Medical Service profoundly, both for good and for ill.

CHAPTER 1

Between the Wars

For the Army Medical Department, the sudden collapse of Japan in August 1945 brought not only peace after four years of fighting but also new and perplexing problems. During the struggle the department had grown to unprecedented size and had achieved extraordinary successes. Yet even before the surrender key personnel had begun to return to civilian life, and in the postwar years the loss of doctors, nurses, scientists, medical administrators, and trained enlisted men became a near hemorrhage that nothing seemed able to stanch. Laboring to fill their depleted ranks, the surgeon general, Maj. Gen. Norman T. Kirk, and his advisers began to reorganize—and indeed rethink—the basic structure and character of their organization.¹

Early plans for the release of personnel envisioned a complex, leisurely process. The War Department demobilization policy rested upon the concept of fairness to all who had borne the battle. Aiming at a partial demobilization after the surrender of Germany in May 1945, the Army discharged those among its enlisted people who had a high Adjusted Service Rating—a numerical score that took into account each individual's length of service, time overseas, combat experience, decorations, and number of dependents. To the degree possible, similar standards governed the discharge of officers. Inevitably, long delays resulted. Desks grew weighty with orders for transfers of high-score units from Europe to the United States and of low-score organizations from Europe to the Pacific or the zone of interior to the fighting fronts.

In the early summer of 1945, facing a rising chorus of complaints, the Office of the Surgeon General (OSG) sought to justify itself. "Equity in separations," declared a memorandum, "means delay in separations of between five and seven months." Pleading that the whole complex process was essentially "sound and just," the planners anticipated in July that the strength of the Medical Corps could be reduced only by some seven thousand over the next ten months.

¹The wartime experiences of the Army Medical Department—the official designation of the Army Medical Service prior to June 1950—are detailed in two volumes of the Center of Military History's United States Army in World War II series, *The Medical Department: Hospitalization and Evacuation, Zone of Interior* (1956) by Clarence McKittrick Smith and *The Medical Department: Medical Service in the Mediterranean and Minor Theaters* (1965) by Charles M. Wiltse. Completing the Army's account are two forthcoming works, *The Medical Department: Medical Service in the War Against Japan* by Mary Ellen Condon-Rall and Albert E. Cowdrey, and *The Medical Department: Medical Service in the European Theater of Operations* by Graham A. Cosmas and Albert E. Cowdrey. The Office of the Surgeon General also published its own World War II series, *The Medical Department, United States Army*, consisting of some forty clinical volumes.

Ironically, on 6 August, the day the first atomic bomb destroyed Hiroshima, the OSG reaffirmed a policy that considered neither the possibility of a quick end to the Pacific war nor the imminent unleashing of a force scarcely less explosive: the demand of the citizen soldier to go home.²

The Great Unraveling

"Since the termination of hostilities," wrote a medical officer awaiting discharge in December 1945, "the change in attitude has been unbelievably abrupt. The uppermost question is the probable or possible date of return to civilian life. . . . Complaints which during the war were voiced but not used as a means for the avoidance of duty, became foremost in conversation."³

The problem went beyond the Medical Department, and indeed beyond the Army. Though aware of Soviet ambitions and power, and reluctant to demobilize quickly, the War Department had little choice but to bow to the public demand that already was causing Congress and President Truman to genuflect. Yet no return to the small garrison Army of pre-World War II days was possible. By leading the Western Alliance during the war, by incurring occupation duties, and by emerging into the postwar world as the greatest power on the globe, the United States had achieved a position from which it was not free to back away. During the five years between June 1945 and June 1950 the Army would lose 86 percent of its wartime officer strength and 91 percent of its enlisted strength. Yet even at the low point it still would be nearly three times as great as in June 1940. Because American servicemen remained posted throughout the world, the nation's military leaders faced problems not only of declining strength but also of large and fundamentally irreducible commitments. From the standpoint of the Medical Department, the shrinking postwar Army remained persistently too large to support in view of the medics' special problems of recruitment.⁴

The full dimensions of the problem, however, would emerge only with time. For the moment what mattered was the almost frenzied demand of the citizen soldier to return to civil life as soon as possible. All the pent-up resentment of Army duties and Army ways, the hurry-up-and-wait of Everyman's military experience, contributed to the drive; so did the confused and turbulent mood of the autumn of 1945, when half the world seemed waiting to go home. Soon OSG officers were complaining of "continued pressure from Congress, the public, the adjutant general, the WDGS [War Department General Staff]" for the release of personnel. At the same time, they were obliged to concede the continuing problems of delay, uncertainty, and confusion that attended a process now aimed at

²Copy of Policy Statement, Office of the Surgeon General, USA, 31 Jul 45, sub: Medical Department: Redeployment and Separation Policy, pp. 13-14, HSF (OSG Policy-1945), HRB.

³Copy of Ltr, Lt Col Paul N. Mutschmann, MC, AAF Regional Station Hospital, to Maj Gen Paul R. Hawley, MC, c/o Surgeon General's Office, USA, 3 Dec 45, HSF (Mutschmann-1945), HRB. Hawley was the former chief surgeon of the European Theater of Operations.

⁴U.S. Department of Defense, *Selected Manpower Statistics*, May 1978, pp. 20, 25-26, file 050 (Statistics), HRB; Russell F. Weigley, *History of the United States Army, The Wars of the United States* (New York: Macmillan, 1967), p. 436.

discharging men and women from service rather than transferring them to the Pacific.⁵

Pressed by the lawmakers, General Bliss, then assistant surgeon general, assured a Senate subcommittee in October 1945 that “separations are now one of our important missions.” Physicians, he pointed out, were going faster than other men in uniform, for the 7,213 released since V-E Day represented about 16 percent of the Medical Corps’ strength, while total separations represented only 15 percent of the Army as a whole. Bliss promised that, except for Regular Army personnel, men wishing to remain, and graduates of special training programs with military obligations to fulfill, “every doctor now in the Army will be returned to civilian life by the end of next summer.” For the meantime, he requested their understanding of the fact that—with a force of more than 7 million men, a patient load of almost four hundred thousand, and monthly separations of about 1 million to process—“the Army still needs doctors.”⁶

Here, in fact, was the crux of the matter: Medical personnel were wanted everywhere—in civilian life, in hospitals where wartime casualties still demanded care, in the forming occupation forces, among the multitudes of refugees threatened by epidemics, and in the separation centers where millions of physicals had to be given. Medical personnel were not just a part of the process of demobilization; they were a key to its success.

Yet whatever difficulties the Army as a whole had to face in retaining key workers, those before the Medical Department were greater. This was the penalty the medics paid for having so great a proportion of educated, eminently employable people. From the brain surgeon to the medical technician, civilian life usually promised greater rewards in money, freedom, and professional opportunity. This was especially true in regard to doctors. Members at one time of an ill-paid, inept, overcrowded profession, American physicians by the end of World War II had become expert, organized, restrictive, and, on average, quite prosperous. A postwar study showed civilian doctors in the “top three percent national income bracket.”⁷ Most were entrepreneurs as well as professionals, ill-adapted by training and habit to military ways.

No single factor—not even income—told the whole story behind the Army’s inability to retain its medical personnel. Studies carried out with doctors indi-

⁵Quoted words from extract of Memo, Lt Col E. R. Whitehurst, MAC, Chief, Enlisted Branch, OSG, to Chief, Personnel Division, OSG, 21 Dec 45, HSF (Whitehurst–1945), HRB. See also Statement of Brig Gen Raymond W. Bliss, Assistant Surgeon General, USA, 17 Oct 45, in U.S. Congress, Senate, Committee on Military Affairs, *Demobilization of the Armed Forces: Hearings on S. 1355*, 79th Cong., 1st sess., 17–18 October 1945, pt. 2 (Washington, D.C.: Government Printing Office, 1945), p. 190.

⁶Quoted words from Statement of Bliss in *Demobilization . . . Hearings on S. 1355*, pp. 188–90. See also MFR, Military Personnel Division, OSG, 28 Aug 45, sub: On Active Duty in the Medical Department, 30 June 1945, HSF (OSG Division–1945), HRB. The War Department instructed commanding generals to ignore table of organization and equipment requirements in order to release doctors, dentists, and nurses as soon as decreasing work loads permitted. See War Department Circular no. 307, 6 Oct 45, p. 2, para. 3.

⁷Quoted words from Special Plans Branch, Medical Plans and Operations Division, OSG, Report of Activities, 1 Jan–30 Jun 49, file 319.1–2 (OSG, Annual Reports), HRB. On the social history of American medicine, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

cated that their lack of interest in Army careers was based largely on professional grounds, and on the demand for individual freedom. A 1946 poll of 386 medical officers who had entered the service through the Army Specialized Training Program showed that only one planned to apply for a regular commission, and “*two out of three* said they would like to get out of the Army *right now*, if it were possible.” A similar majority said that they could not be induced to serve an additional two years under any conditions. The men cited many dissatisfactions—with professional assignments, financial compensation, and living conditions. But heading the list was a fundamental dislike of the military itself, and its tradition of impersonal mass medicine. “The Army is totalitarian not a democracy,” said one respondent. “If a doctor practices in the Army, he is not much better off than if he were in Germany or Russia.” Another said flatly, “I wanted to be a doctor and I feel that I cannot be a doctor in the true sense of the word while I’m in the Army.”⁸

The situation in the other health care professions was somewhat similar. In June 1946 a group of 210 nurses assigned to one installation in the zone of interior were polled on their interest in Army careers. Only 15 indicated a desire for Regular Army appointments, and of these 6 had such poor efficiency ratings as to be ineligible. Technical experts of all kinds were similarly hard to keep, as were trained enlisted people. The surgeon general attempted to retain scarce technicians, in some cases awarding additional rank as compensation for delayed release. But the decline in strength was rapid, and as a result critical shortages developed, especially in the zone of interior. Sometimes, even when officers were available, trained enlisted men were not. The scarcity of X-ray and laboratory technicians caused continual complaint.⁹

Meanwhile, changes in policy reduced the whole process of discharge to a muddle. In response to congressional and popular pressures, the scores necessary for separation were revised downward repeatedly, but news of the changes did not always reach those who needed to know. The chief of the OSG’s Enlisted Branch, engaged in a daily struggle for manpower, learned of one such change only by reading his newspaper. Some separation centers, he knew, were discharging men under one set of criteria, some under another.¹⁰

One possible source of personnel was deliberately ignored during the demobilization. Queries from Congress and the General Staff about blacks in the Medical Department were met firmly by statements that the 4 percent of “colored” strength in the department during World War II was the “maxi-

⁸Copy of Study, Troop Attitude Research Branch, Information and Education Division, WD, 2 Nov 46, sub: Attitudes of A.S.T.P. Medical Officers Toward Service in the Regular Army, HSF (ASTP-1946), HRB.

⁹Extract from Memo, Eli Ginzberg, Director, Resources Analysis Division, OSG, to Assistant Chief of Staff, G-1, 25 Jan 46, sub: Trends in Medical Demobilization Since V-E Day, HSF (Ginzberg-1946), HRB. See also Nursing Consultants Division, OSG, History of Nursing Branch, 1 Apr-30 Jun 46, file 319.1-2 (Personnel Service) Military Personnel Division, OSG, FY 1946, HRB. Between V-E Day and July 1946 the number of Army doctors fell from 45,000 to 8,500; of dentists, from 14,500 to 3,500; and of nurses, from 52,000 to 9,000.

¹⁰Extracts from Memos, Lt Col E. R. Whitehurst, MAC, Chief, Enlisted Branch, OSG, to Chief, Personnel Services, OSG, subs: Weekly Diaries Ending 21 Sep, 5 Oct, and 19 Oct 45, HSF (Whitehurst-1945), HRB.

mun . . . that can be effectively utilized. . . .”¹¹ The medical unit best adapted for blacks, in the surgeon general’s opinion, was the Sanitary Company. Experience had “proven that it is neither practicable nor desirable to utilize colored units for the care and treatment of white personnel.” As the troop basis for the Army Reserve was revised, sanitary units were lost, and the implication was clear that medical posts for black enlisted men in either the Reserve or the Regular Army would be at a minimum.

The picture with officers was similar. Apparently, the first time the Medical Department had any black regular officers was in August 1949: four in the Medical Corps, two in the Women’s Medical Specialist Corps, and three in the Army Nurse Corps. By the middle of 1950—with the department’s own needs great, racial integration under way, and national policy strongly in favor of increased opportunities for blacks in the Army—the Medical Service, as it was then called, had 142 black officers and 2,057 enlisted men. Of the officers, only 14 were Regular Army. While the medics were not completely rigid in their opposition to black personnel, their record in the postwar years would show them to be conservative, cautious, and generally wedded to the Army’s tradition of segregation.¹²

In other ways the surgeon general moved to counter the personnel problem. In the spring of 1946 a reorganization of the War Department expanded his authority and gave him more direct access to the chief of staff. In April, in anticipation of the coming abolition of a superior headquarters called the Army Service Forces (ASF), hospitals formerly under the ASF commanding general were transferred to the surgeon general’s control, more than doubling the number of OSG field installations. The inactivation of the Army Service Forces that followed in June simplified the organizational structure and afforded the surgeon general, as it did other service chiefs, a better opportunity to make himself heard. Henceforth, he enjoyed greater freedom to meet his many problems than his predecessors had had since the early days of the Second World War.¹³

Foremost among the surgeon general’s problems, and the key to understanding many of his actions in other fields, was his effort to attract and keep the skilled personnel that the Medical Department needed to function. Reform and reorganization were to make the postwar years a major formative period in the history of Army medicine.

The ASTPs

In meeting the need for doctors, the surgeon general had a cushion in the graduates of the Army Specialized Training Program (the ASTPs). Under this

¹¹Extract from Memo, Brig Gen Guy B. Denit, Acting Surgeon General, USA, to Director, Organization and Training, WDGS, 28 Jun 46, sub: Organization of Negro Manpower in Postwar Army, HSF (Denit-1946), HRB.

¹²Department of the Army, *Strength of the Army*, 31 Aug 49 and 30 Jun 50, LIB. It should be noted that some of the early black medical officers—Col. John F. Harris is an example—achieved distinguished careers in the Medical Department.

¹³Extract from Civilian Personnel Service, OSG, Quarterly Historical Report, 1 Apr-30 Jun 46, (Continued)

and similar World War II programs, the armed services since 1942 had made an unprecedented commitment to help select promising enlisted men, to defer them, and to finance their professional training in a number of critical fields, including medicine, dentistry, and veterinary medicine.¹⁴

Early in the war, military demands had alarmed universities and graduate schools, including schools of medicine and its allied sciences, which saw themselves likely to be deprived of students by drafting en masse. Hence in September 1942, over the objections of the assistant chief of staff, G-3, who believed that "from a strictly mobilization viewpoint, the value of the program was nil," provision was made for 150,000 selected enlisted men who had completed basic training to receive technical and professional education in civilian universities and colleges at government expense. Launched in December of the same year, the program provided in part for a future supply of trained doctors, dentists, and veterinarians who would help to staff civilian hospitals during their internships and residencies, and later be commissioned into the appropriate corps of the Medical Department to serve during the national emergency. In some related professions, such as sanitary engineering, similar arrangements were made but no commission was assured. The costs of the program were considerable. The government paid tuition, fees, and living expenses for some young men destined for medical careers, relieving their families of the burden. When the medical program ended in June 1946, some 13,373 young physicians had emerged from it with military obligations that were fixed in November at three years of active service.¹⁵

In the postwar years the experiences of the Medical Department with the ASTPs were not, by and large, happy ones. Men who felt they had committed themselves to serve during the emergency were not always eager to fulfill a military obligation during peacetime, for they preferred to begin establishing their practices. Many ASTPs displayed considerable energy in obtaining the support of their congressmen and professional associations in fighting OSG efforts to compel them to serve at times or under conditions that were inconvenient to them. Early in the Korean War the surgeon general would make a harsh judgment: "The ASTP's were the most disgruntled lot of doctors ever encountered by the Army. . . ." Yet many of the ASTPs served quietly if not enthusiastically and for years after World War II provided the main, indeed almost the only sure, source of replacements for the doctors who had left the Army.

Contemporary records clearly reveal the extent of the Army's dependence on these often unwilling soldiers. In November 1945 about 4,500 ASTPs were on

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HSF (OSG Divisions-1946); extract from Memo, Maj Gen Norman T. Kirk, Surgeon General, USA, to Director, Organization and Training, WDGS, 19 Jun 46, sub: Integration of AUS Officers into the Medical Department, HSF (Kirk-1946). Both in HRB.

¹⁴A basic document on the Army program is: Col Francis M. Fitts, MC, "Training in Medicine, Dentistry, and Veterinary Medicine . . . Under the Army Specialized Training Program, 1 May 1943 to 31 December 1945," Ms no. 3-4 BA, RG 319, MMHB.

¹⁵Quoted words from Interv with Maj Gen Harry L. Twaddle, n.d., HRB. Twaddle was an expert on the draft laws. See also Marvin A. Kreidberg and Merton G. Henry, *History of Military Mobilization in the United States Army, 1775-1945*, DA Pamphlet 20-212 (Washington, D.C.: Department of the Army, 1955), p. 635.

¹⁶SG Conference Notes, 26 Jul 50, Medical Collection, HRB.

TABLE 1—MEDICAL DEPARTMENT OFFICER STRENGTH, DECEMBER 1947

Component	Total	Regular Army	
		Actual	Authorized
Medical Corps	7,702	1,206	3,000
Dental Corps	1,652	432	743
Veterinary Corps	399	198	186
Medical Service Corps	2,762	740	1,022
Army Nurse Corps	4,960	1,148	2,258
Women's Medical Specialist Corps	512	142	409
Total	17,987	3,866	7,618

Source: Extract, HSF (Officer Strength-1947), HRB.

active duty. In April 1946, 3,654 more came on duty, and in July, another 1,465. Taking losses into account, by mid-1946 more than 5,000 new ASTPs were in uniform. Not only the Army but also other agencies needed them. Though the Navy had operated a similar program known as V-12, it was obliged to call upon the Army for 291 ASTPs, while the Veterans' Administration took 1,000 and the Army Air Forces 512. So useful were the ASTPs that for a time the manpower situation was reversed. Because the services were shrinking rapidly under congressional cutbacks, and the lawmakers failed to enact Universal Military Training as had seemed likely in 1946, the supply of doctors began to exceed the demand. By summer the consensus was that even a two-year service obligation for ASTPs would oversupply the needs of the Army. The length of service was reduced accordingly, and the brightening situation resulted in a call for fewer ASTPs during 1947.¹⁷

For a few months in the spring of the year, the Office of the Surgeon General enjoyed the prospect of an impending surplus of medical officers. This surplus, however, failed to materialize, and by the end of the year 1,800 regular slots went unfilled (*Table 1*). Shortly afterward, new figures painted a more realistic picture. Massive separations loomed in early 1948, and efforts to freeze the ASTPs looked politically unwise. By 1 July, estimated the deputy surgeon general for plans, the ASTPs "will be a majority of the 5,000 Medical Corps officers then on duty, and the Medical Department will not be able to perform its mission without them. . . ."¹⁸

¹⁷Extracts from MFRs, Capt H. E. Klarman, 24 Nov 45, sub: ASTP Medical Students; Isaac Cogan, 7 Mar 46, sub: ASTP's Coming on Duty; and Lt Col Rice, 9 May 46, sub: Calling of ASTP to Active Duty, HSFs (Klarman-1945), (Cogan-1946), and (Rice-1946), HRB. See also extract from Memo, [Cogan] to Assistant Chief of Staff, G-1, 10 May 46, sub: Availabilities and Requirements—Medical Corps, HSF (Cogan-1946); copy of Memo, James Forrestal, Secretary of the Navy, to the President, 17 May 46, sub: Medical and Dental Service of the Armed Forces, HSF (Forrestal-1946); extract from Assignments Branch, Military Personnel Division, OSG, Quarterly Report of Activities, 1 Apr-30 Jun 46, HSF (OSG Divisions-1946); extract from Memo, Cogan to Office of Personnel, 25 Oct 46, HSF (Cogan-1946); extract from Memo, Lt Col W. N. Piper, Chief, Procurement, Separation, and Reserve Branch, Personnel Division, OSG, to Chief of Personnel, 29 Oct 46, HSF (Piper-1946). All in HRB.

¹⁸Quoted words from copy of Memo, Brig Gen Guy B. Denit, Deputy for Plans, OSG, to Director, Personnel and Administrative Division, WDGS, Attn.: Brig Gen A. G. Trudeau, 1 Jul 47, sub: Retention of ASTP Officers on Duty, HSF (Denit-1947), HRB. See also extract from MFR, Isaac Cogan, Chief, Resources Analysis Division, OSG, 25 Mar 47, sub: AAF Requirements for Medical ASTP Graduates Being Called to Duty, July-December 1947, HSF (Cogan-1947). For

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Despite the friction that sometimes attended the ASTPs' service, they proved to be absolutely indispensable. They contributed only a limited number of professionals to the war, but they markedly eased the bumpy first years of transition to peace. By and large, they served well, many of them overseas, in posts that included the unpopular ones in Korea and Okinawa. The last of those to serve during peacetime in the Far East, their obligation ended, sailed for home in May 1950, one month before the outbreak of the Korean War.¹⁹

The Drive To Professionalize

Who was to take the place of the ASTPs? Using the breathing space the program had gained them, Surgeon General Kirk and his advisers came to conclusions that implied a drastic break with Army medicine's recent past.

"You wouldn't believe it," said a retired general officer at a later time, reflecting on his career, "but in the Thirties, up until I left Walter Reed in 1939, we of the Medical Corps of the Army were not specializing."²⁰ This was an exaggeration, for military specialties, notably in surgery, had existed before World War II. But the Army doctor was more commonly a jack-of-all-trades, and often times a soldier as much as he was a physician.

Kirk believed that change was essential. Writing to the chief of staff on 20 December 1946, he averred that "much of the unwillingness of the young physician to enter military service is due to his belief that the Army denies to him . . . opportunities for professional advancement, postgraduate education, for specialization, for certification by professional specialty boards, and for clinical research and self expression."²¹ The conclusion was evident. Because the Army could not match the monetary rewards of a successful private practice, it must expand the physician's professional opportunities in the postwar Army. At the upper end of the Medical Department's personnel spectrum, training was inseparable from procurement.

However, the retention of young officers and the gaining of new ones was only one aspect of the program of professionalization. During World War II Regular Army medical officers had occupied administrative posts, and civilians and reserve officers, brought in for the duration and awarded Army of the United States commissions, had done most of the doctoring. The departure of

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personnel estimates, see copy of MFR, Lt Col Rice, 20 Jun 47, sub: Distribution of Incoming ASTP, HSF (Rice-1947). Both in HRB. General Bliss rejected the proposals to freeze ASTPs due for release in 1948 on grounds of fairness and the impact on civilian medicine. See, for example, SG Conference Notes, 5 May 48, HRB.

¹⁹Copy of Memo, Isaac Cogan, Chief, Resources Analysis Division, OSG, to General Bliss, 24 Mar 48, sub: Freezing of ASTP?, HSF (Cogan-1948), HRB; Fitts, "Training . . . Under the Army Specialized Training Program," Supplement to 30 June 1946, p. 3, MMHB.

²⁰Interv, Graham A. Cosmas and Dwight D. Oland with Brig Gen Sam F. Seeley, MC (hereinafter cited as Seeley Interv), 14 Aug 79, sess. 2, cassette 5, p. 36, HSF (Seeley-1979), HRB. Seeley, a surgeon who commanded the 100th General Hospital in the European Theater of Operations, subsequently was chief of Surgical Service at Brooke General Hospital and, as of July 1949, at Walter Reed Army Hospital.

²¹Copy of Memo, Maj Gen Norman T. Kirk, Surgeon General, USA, to Chief of Staff, USA, 20 Dec 46, HSF (Kirk-1946), HRB.

the latter at war's end forced upon the Medical Department the massive job of retraining regulars and advancing at least some of them in clinical specialties. "We have," noted an OSG officer as late as 1948, "about one-seventh the number of highly qualified professional experts we need while at the same time we have about twice the number of administratively trained officers we need."²²

The new program was to have a considerable impact on the character of the Medical Corps, and hence upon the Medical Department as a whole. Professional skills acquired far greater importance than in the 1930s. In time, credentials in a clinical specialty became essential to career advancement. Thereby the Army doctor drew closer to the model already established by his civilian colleagues. As the Society of United States Medical Consultants in World War II declared, "The concept of the Army medical officer as a general practitioner, capable of doing medicine, surgery, and certain specialties, and trained in military medicine as well . . . is wholly against the trend of the times, and if the [Medical] Corps set this up as an objective it would be impossible to induce good men to make Army medicine a career."²³

The overall program developed during 1946–49 was complex and aimed at a general upgrading of the Medical Department. The training of doctors, however, was clearly foremost in the mind of the surgeon general. Through the promise of reserve commissions, the department reached out to the student, as medical, dental, pharmacy, and veterinarian ROTC units were reestablished. By 1950 these units were in place at forty-nine medical schools, with a total enrollment of over four thousand cadets. The surgeon general assigned younger officers in the schools as professors of military science and tactics, allowing them to study at the institutions where they taught. By bringing higher caliber and more enthusiastic leaders to the ROTC programs, a traditional source of Army Reserve officers was revitalized. In the same spirit the practice of affiliation was revived in 1947, enabling civilian hospitals and medical schools to sponsor and staff reserve units. Internships were established in Army hospitals, with the lure of a first lieutenant's pay for those who were accepted. Such slots were filled consistently, though often the most desirable candidates declined to serve.²⁴

For those already in the Army, an array of training was provided that ranged from Army schools to leading universities. The Medical Field Service School at Fort Sam Houston, Texas, the St. Louis Medical Depot, the Army Medical Research and Graduate School, and several general hospitals offered a profusion of courses for officers and enlisted people. When in-house training was not

²²Raymond E. Duke, "Training Activities of the Army Medical Department," *Military Surgeon* 102 (May 1948): 339.

²³Quoted words from Resolution, Society of U.S. Medical Consultants in World War II, 4 Jun 49, in Colonel Robinson's Studies, file 322.051 (Col Robinson's Studies), Box 31, Accession no. 58A-1095, RG 112, WNRC. On career patterns, see War Department Technical Manual 12-425A, Personnel Classification, July 1947, LIB; Department of the Army Technical Manual 20-605, Career Management for Army Officers, June 1948, LIB; Paul I. Robinson, "About the Medical Corps," *Bulletin of the U.S. Army Medical Department* 8 (August 1948): 592–601.

²⁴"Medical Department Training Program," Statement to the Association of American Medical Colleges, 6 Feb 48, in *Military Surgeon* 102 (April 1948): 304–05; Office of Deputy for Plans, OSG, Report of Activities, 1 Jul–31 Dec 47, file 319.1–2 (OSG, Annual Reports), HRB; "Medical Department Affiliation Program," *Bulletin of the U.S. Army Medical Department* 9 (August 1949): 700–703.

available, selected members of the Medical Department were sent to civilian institutions to study, not only medicine, surgery, and dentistry but also bacteriology, business administration, hospital management, chemistry, medical librarianship, nursing education, and biochemistry.

The crown of the program was the system of postgraduate medical education in Army hospitals, which was made available both to officers and to qualified civilians interested in a reserve commission. Residencies were set up in five Army general hospitals, which were designated as teaching hospitals. By mid-1948 a total of 376 residents were in training. Every effort was made to meet the most exacting standards of modern medicine in preparing these future specialists. During World War II civilian physicians distinguished in their fields had served the Medical Department as consultants, providing expert advice and professional guidance. In 1946 their status was made permanent. Now such men were sent into the teaching hospitals part-time to aid the training of the young residents—"a practice," noted the surgeon general, "which incidentally has gone far to improve relations with the civilian medical profession." Seemingly, the program had something to offer everyone.²⁵

Yet the endeavor, though successful in upgrading the Medical Department, failed to provide enough doctors in time to meet the personnel crisis threatened by the end of the ASTP supply. Lack of top-level support could not be blamed. The year 1947 brought in a new surgeon general, Major General Bliss, who provided able and committed leadership to the effort to improve the professional quality of Army medicine. In the same year Congress voted a pay raise for non-ASTP doctors and dentists. In 1948 the Office of the Surgeon General launched an emergency program to enable residents and interns in civilian institutions to accept commissions while continuing their studies where they were. Some regulars also were allowed to train in civilian hospitals. But after all available suitable personnel were commissioned, the department still faced a shortage of some twelve hundred medical officers.²⁶

Reorganizing the Department

At the end of World War II the Medical Department contained six corps—Medical, Dental, Veterinary, Army Nurse, Medical Administrative, and Pharmacy. A seventh, the Sanitary Corps, was a reserve organization. Each regular corps provided a vertical organization for officers, based on professional specialty, and possessed a mission, history, and collective personality of its own. All but the Army Nurse Corps were comprised exclusively, or overwhelmingly,

²⁵Quoted words from extract of Rpt, Section on Development in the Medical Field, p. 19, Encl to Memo, Col Thomas J. Hartford, MC, Executive Officer, OSG, to Chief, Control Office, Logistics Division, DA, 10 Sep 48, sub: Annual Report of Secretary of the Army for Fiscal Year 1948, HSF (Hartford-1948), HRB. See also copy of SGO Circular no. 5, Office of the Surgeon General, DA, 13 Jan 48, HSF (SGO Circular-1948), HRB.

²⁶Surgeon's Circular Letter 5, no. 1, Medical Section, FEC, 1 Jan 50, pp. 4-6, file 300.5 (Circular Letters) FEC, HRB. On the pay raise, see War Department Bulletin no. 21, 28 Aug 47, LIB, and Public Law no. 80-365, 5 Aug 47.

of men; the nurses were all women. The Medical Corps, composed of physicians, far outweighed the others, both in number and in power.

Throughout, the corps structure revealed the duplications and anomalies of an organization that had "just grown," and to giant size at that, subject to many pressures amid the changing needs of war and peace. To simplify the structure, to establish a measure of parity between its male and female members, and to provide incentives to bring the array of needed talent in from civil life would be no easy task.

The Medical Administrative Corps was long the Cinderella of the department. Organized in 1921, the corps was limited to a few score officers until World War II, because physicians held most of the department's administrative posts and brooked no competition. The war transformed the corps, multiplying its numbers and bringing it new importance and many new duties. Administratively trained Regular Army doctors proved too few to fill the vast number of such posts in the Office of the Surgeon General and in various headquarters, hospitals, laboratories, and medical field units. Additionally, a melange of specialists entered the Medical Administrative Corps, including optometrists, opticians, and experts in supply, in the construction and operation of medical equipment, and the like. The importance of such men was rising as medicine became more complex and more technical, and the corps emerged from the war as a catchall of the allied professions.

The small Pharmacy Corps dated only from 1943, but the political muscle of the nation's pharmacists that created it was in evidence for a longer time. From 1936 to 1943 the pharmacists also dominated the Medical Administrative Corps, whose regular commissions went only to them. Then a well-organized lobbying effort won a separate corps from Congress, against the wishes of the surgeon general. The Pharmacy Corps remained limited in numbers and considerably more varied in function than its name implied. The Sanitary Corps was an organization all of whose officers held either reserve or Army of the United States commissions. Containing a range of experts from laboratory technicians to sanitary engineers, the corps duplicated many of the administrative and technical features of the Medical Administrative Corps and Pharmacy Corps.

The problems of recruiting nurses were severe enough to underscore the need of greater status for the Army Nurse Corps. Together with a group of female dietitians and therapists not yet organized as a corps, the nurses since 1944 had held Army of the United States commissions in place of the restricted status and privileges earlier allowed them. By early 1947, however, female officers who



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wished to remain in the Army were in a dubious position. Impending congressional repeal of the law under which their commissions were granted meant that nurses, unless awarded Regular Army commissions hitherto denied them, would lose their hard-earned status in mid-1948.²⁷

Unable to secure the services of enough women with military experience, the War Department in January 1947 authorized appointment of 300 nurses without such a background. Because the corps had 500 vacancies, and anticipated the separation of 1,000 nurses who were then in uniform, a major effort to secure new officers and persuade veterans to reenlist was clearly in order. Directors of nurses in the various Army areas sent out applications, and OSG's Nursing Division approached 1,068 nurses who had at some time indicated an interest in an Army career. On the whole, results were discouraging. By the end of March only 101 had replied, and of these 33 had to be rejected, while 4 declined appointment.²⁸

In April Congress authorized Regular Army commissions for Army nurses. At the same time, the lawmakers gave further recognition to the Medical Department's professional women by establishing a Women's Medical Specialist Corps for dieticians, physical therapists, and occupational therapists. They authorized a minimum strength of 2,558 for the Army Nurse Corps and 409 for the Women's Medical Specialist Corps. In June the first list of Army nurses nominated for the Army Nurse Corps, Regular Army, went to the president. By the end of the year 1,201 nurses, therapists, and dieticians received offers of commissions and 1,143 accepted. Because a nurse section of the Officers' Reserve Corps now existed as well, reserve commissions were offered to nurses without previous service. In July Congress abolished Army of the United States commissions, effective 1 July 1948; by that time, all Army nurses must become either regulars or reservists. The changeover presented the Army an opportunity to eliminate nurses who had proved unsatisfactory. Others, however, were lost because they chose to leave, or because they had young dependents, or because they were over 35 years of age.²⁹

Such doubtful criteria eliminated women who hardly could be spared. Losses during 1948 were over a thousand as nurses with Army of the United States commissions departed. In the Nurse Corps, as in the Medical Corps and Dental Corps, much time was spent taking head counts that always came up short when measured against need. Counting up the results when the integration program

²⁷On the early history of therapists and dieticians in the Medical Department, see Harriet S. Lee and Myra L. McDaniel, eds., *Army Medical Specialist Corps* (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1968), pp. 1–338. The possibility of employing male nurses was discussed at the Office of the Surgeon General, but with evident disapproval. See SG Conference Notes, 31 Mar 49, HRB.

²⁸Nursing Division, OSG, History of Army Nurse Corps Personnel, 1 Jan–31 Mar 47, file 319.1–2 (OSG, Annual Reports), HRB.

²⁹Public Law no. 80–36, 16 Apr 47. Extract from War Department Personnel News Letter no. 8, 10 Jul 47, p. 1, HSF (WD News Ltr–1947); Nursing Division, OSG, Report of Activities, 1 Jul–31 Dec 47, file 319.1–2 (OSG, Annual Reports); and Personnel Division, OSG, Report of Activities, 1 Jul–31 Dec 47, file 319.1–2 (OSG, Annual Reports). All in HRB. War Department Circular no. 189, 22 Jul 47, and Department of the Army Circular no. 79, 29 Dec 47, LIB. "Regular Army Appointments in Women's Corps," *Military Surgeon* 101 (December 1947): 536. On the end of Army of the United States commissions, see Public Law no. 80–239, 25 Jul 47.

TABLE 2—DISTRIBUTION OF ARMY NURSES, JUNE 1948

Major Commands and Other Organizations	Strength
Alaska	18
Antilles Department	40
Air Force	546
Brazil	1
China	5
European Command	316
Far East	407
Hawaiian Department	77
Panama	31
Class II Installations	1,730
Transportation Corps	179
Trieste Theater	17
Zone-of-Interior Army Areas ^a	739
Noneffective	204
Total	4,310 ^b

^aIncluding the Military District of Washington.
^bRegular Army nurses numbered 1,470; Reserve Corps nurses, 2,840.
Source: Army Nurse Branch, Nursing Division, OSG, Quarterly Report of Activities, 1 Apr–30 Jun 48, p. 1, file 319.1-2 (OSG, Annual Reports), HRB.

was completed, different OSG divisions arrived at slightly varying conclusions, none satisfactory. A total of 1,756 nurses had been nominated for Regular Army commissions, while 995 had been disqualified. With the addition of a small group of veterans who had left the Army but now returned, about 1,558 had taken the proffered rank. By various estimates, either 3,800 or 5,700 nurses more would be needed—reservists, civilians, or other—to meet the requirements of the Army in the year ahead.³⁰

However calculated, the needs were great and would grow worse. The distribution of nurses (*Table 2*) reflected the worldwide commitments of the United States. The onset of the Cold War during 1947 and 1948 signaled increased duties without adequately augmented personnel, for women could not be drafted and, under the rigid codes of the time, men, though they could be orderlies, could not be military nurses. Various expedients were tried. Civilian nurses were employed on contract—supposedly on a temporary basis, until uniformed nurses could be obtained. In fact, however, the use of civilian nurses soon became a standby in Army hospitals. Reserve nurses became increasingly important, until reservists on extended active duty dominated the corps in numbers. Far from being phased out, the allotment of civilian nurses increased, and a course of instruction in practical nursing was established for enlisted men at Walter Reed Army Hospital. In many hospitals the eight-hour day for nurses had to be abandoned, increasing procurement problems because civilian nurses were accustomed to such a schedule. Despite all efforts, the phrases “critical shortage” and “matter of grave concern” became refrains in reports and personnel newsletters.³¹

³⁰Army Nurse Branch, Nursing Division, OSG, Quarterly Report of Activities, 1 Apr–30 Jun 48, pp. 1–3, file 319.1–2 (OSG, Annual Reports), HRB.

³¹Quoted words from Department of the Army Personnel News Letter no. 15, 1 Oct 48, p. 7, HSF (DA News Ltr–1948), HRB. See also Nursing Division, OSG, Report of Activities, 1 Jul–31 Dec 47, (Continued)

A further blow came in 1949 with the establishment of a separate Air Force Nurse Corps. Army nurses could now choose the service they wished to continue in, and on 26 July 1,199 nurses, including 307 regulars, transferred to the Air Force. Because the Army also was caring for Air Force patients, creation of the new service reduced its obligations as well as its personnel. Nevertheless, the corps completed its last full year of peacetime before the onset of the Korean War severely depleted in number and dependent upon reserve officers on extended active duty. There was a continuing overall shortage of about 500 nurses.³²

Meanwhile, Congress had established another new corps, in large part to counter the shortage of physicians. Planned since the end of the war, the Medical Service Corps united medical administrators with officers in the allied sciences. As a Regular Army component, the corps provided permanent officer slots for personnel whose status, in many cases, had been uncertain. However, the corps faced some opposition within the Medical Department itself, because of professional snobbery or genuine doubts about an organization composed of so many diverse elements. Medical administrators were often former enlisted men commissioned during the World War II burgeoning of the Medical Administrative Corps, and relations between them and degree-holding experts in scientific fields were not always easy. Nevertheless, the importance of the ancillary fields was such that the surgeon general had his way. The organization set up by Congress on 4 August 1947 was divided into seven sections: Pharmacy, Supply, Administration, Medical Allied Sciences, Sanitary Engineering, and Optometry. Dissatisfaction among the pharmacists was lessened by the appointment of Col. Othmar F. Goriup, a member of that guild, as the first Medical Service Corps chief. Three former corps—Medical Administrative, Pharmacy, and Sanitary—ceased to exist by the same act.³³

The tendency toward professionalism evident in the Medical Corps now reappeared in the Medical Service Corps. If willing and qualified, officers of the three abolished corps transferred to the new corps, but provision was made as well for granting commissions to civilians based solely on their professional expertise. "An expert in enzyme chemistry," explained the Medical Section, Far East Command, in reviewing the new law, "can be given a regular commission . . . with no more complications than would be involved in commissioning a brain surgeon in the Medical Corps. . . . The Surgeon General is free to use his discretion as the need arises."³⁴

Yet, though the law had multiple uses—recognizing the allied sciences, simplifying the organization of the Medical Department, and so forth—there can be little doubt that its most immediate advantage in the eyes of the surgeon general

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1 Jul–31 Dec 48, 1 Jul–31 Dec 49, and Personnel Authorization Unit, Personnel Division, OSG, 1 Jul–31 Dec 48, files 319.1–2 (OSG, Annual Reports). Both in HRB.

³²Nursing Division, OSG, Report of Activities, 1 Jul–31 Dec 49, HRB.

³³Public Law no. 80–337, 4 Aug 47.

³⁴Quoted words from extract of Surgeon's Circular Letter 2, no. 10, Medical Section, FEC, 1 Oct 47, pp. 3–4, HSF (FEC Circular Ltr–1947), HRB. See, for example, Announcement, "Civilian

was the chance it offered to alleviate the shortage of doctors. To expand and stabilize the complement of medical administrators was essential to the effort to professionalize the Medical Corps. In hospital units, changes in the tables of organization and equipment (T/O&Es) now assured that the only doctor in an administrative post was the commander or, in large units, the commander and his deputy. The same quickly became true of tactical units and supply depots. Medical Service Corps officers took over much of the supply system; small depots and the medical sections of general depots, in the main, functioned without a medical officer on duty. In headquarters staff positions Medical Corps officers usually appeared only as chiefs of major divisions. The T/O&E revisions alone produced a decrease of 7.5 percent in the number of medical officers required by the department. The whole complexion of the organization began to change. In World War II the ratio of administrative and allied sciences officers to physicians was about 1 to 2; by 1951, the ratio was approximately 3 to 4.³⁵

The personnel shortages that developed in the Medical Service Corps were, like the corps itself, a patchwork. In an organization that included such diverse people as depot supply sergeants who had won commissions, clinical psychologists, psychiatric social workers, industrial hygienists, toxicologists, and graduate engineers, differences were to be expected in the relative appeal of military versus civilian life. For former enlisted men, the corps represented an advance in status and earning power. On the other hand, serious recruitment problems developed and persisted primarily in the Medical Allied Sciences Section and, to lesser extent, in the other professional sections. Overall, the Medical Service Corps entered 1948—when, it will be recalled, the surplus of doctors turned into a serious deficiency—with a shortage of 600 officers.³⁶

By 1949 the situation of the corps in terms of total numbers resembled that of the Army Nurse Corps. Among active duty personnel, reservists outnumbered regulars by about 3 to 1, and four hundred vacancies remained unfilled. In terms of its two basic rationales—to relieve doctors of administrative duties and to entice scientists into the Medical Department with regular commissions—the Medical Service Corps, though not without achievements to show in both endeavors, had proven far more successful in the first than in the second.³⁷

Yet the reorganizations of 1947 proved statesmanlike and durable. The structure that developed was comparatively simple and coherent, and gave solid support to professionalization. The status of the Medical Department's female members, on whom it depended and would depend heavily, had markedly improved. The personnel problem was another matter. As quality and organization improved, quantity remained persistently short of need.

Specialists Eligible for Army Reserve Commissions," *Bulletin of the U.S. Army Medical Department* 8 (October 1948): 769.

³⁵Extract from General Robinson's Tour End Report, 1947-1951, HSF (Robinson Report), HRB.

³⁶Extract from Surgeon's Circular Letter 3, no. 6, Medical Section, FEC, 1 Jun 48, p. 2, HSF (FEC Circular Ltr-1948); extract from Personnel Action Branch, Personnel Division, OSG, Quarterly Report of Activities, 1 Jan-30 Mar 48, p.6, file 319.1-2 (OSG, Annual Reports), HRB.

³⁷Career Management Branch, Personnel Division, OSG, Report of Activities, 1 Jul-31 Dec 48, file 319.1-2 (OSG, Annual Reports), HRB.

The Unification Drive

The changes within the Medical Department during 1947–49 were overshadowed by a broader shakeup of the whole defense establishment. The end of World War II compelled basic rethinking of traditional American military dogmas. The atomic bomb, though no one was yet certain how and under what circumstances it could be used, exalted the Air Force, gave new impetus to old arguments for a separate service, and brought into question the future significance of the Army and the Navy. Military budgets, as often happens in a time of peace, became targets of opportunity both for lawmakers who preferred to spend on domestic programs and for the costive who did not wish to spend at all. Under these circumstances administration officials, members of Congress, and members of the services alike discussed and took sides on proposals to give the air arm equal status with the Army and the Navy, to achieve greater unity among the services, and to seek economies through common procurement of supplies and enhanced interservice cooperation. Under its chief of staff, General of the Army Dwight D. Eisenhower, the Army favored maximum unification, especially in the medical field; the Navy, coordination of the services through joint committees, culminating in the war-created Joint Chiefs of Staff. Supporting his chief, Surgeon General Kirk vigorously endorsed a “single, integrated medical service.”³⁸

As Congress took up the issue in early 1947, the onset of the Cold War imparted urgency to the debate. In March 1947 the Truman Doctrine started aid flowing to Greece and Turkey, both of which were facing Communist pressures. The next year brought the Berlin Blockade and a renewed military draft. In 1949 the North Atlantic Treaty was signed. Already operating in China was a military medical advisory group headed at first by Col. Howard S. McConkie and then by Col. Floyd L. Wergeland, both Medical Corps officers. In 1949 a similar mission was established to aid the new Republic of Korea. Supplies, including medical supplies, were sent abroad to friendly and allied nations.³⁹

During 1947 congressional hearings set the issue of medical organization firmly in the context of military unification. Considerations of cost, of a prospective shortage of physicians in the event of war, of a duplication of effort by the Army and the Navy during World War II, and of an underutilization of doctors during the conflict all seemed to demand a new approach. For a time, with the outcome of the debate uncertain, almost anything seemed possible. In his own testimony, Eisenhower indicated a high-level view of the services'

³⁸As given in Richard V. N. Ginn, “Of Purple Suits and Other Things: An Army Officer Looks at Unification of the Department of Defense Medical Services,” *Military Medicine* 143 (January 1978): 18.

³⁹Daniel Yergin, *Shattered Peace: The Origins of the Cold War and the National Security State* (Boston: Houghton Mifflin, 1977), pp. 275–394; Mae Mills Link and Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service, 1907–1949* (Washington, D.C.: Office of the Surgeon General, U.S. Air Force, 1969), pp. 106–44. On the Wergeland mission, see extract from Rpt, Army Advisory Group, Combined Services Division, 6 Oct 47, sub: Surgeon, Army Advisory Group (Senior Medical Officer), pp. 1–3, HSF (Army Advisory Group Report), HRB.

medical problem and of some possible solutions. The problem he termed "one of the hardest . . . we have got in the Army," pointing out to members of the Senate Committee on Armed Services that "we have fewer doctors today in the Army, in the Regular Service, including the ones who have recently accepted commissions, than we did when the war started." He wished to see a unified medical service for the unified armed forces, and he revealed that he was also thinking of the possibility of combining the medical services of the Army and the Veterans' Administration. Reflecting on the implications of the atomic bomb, he felt that the medical situation demanded "more planning, more brains, . . . than almost anything I can think of."⁴⁰

In July, however, Congress passed the National Security Act of 1947, setting up a National Military Establishment of three armed services, each under its own secretary, with a secretary of defense as the president's principal assistant in national security matters. This halfway house between separate services and true unification was in considerable measure the work of the secretary of the Navy, James Forrestal, representing the views of the second oldest but most tradition-minded service. On 17 September 1947, however, Forrestal became the first secretary of defense. He quickly found his position to be weak and began to call for strengthening its powers. The task of being, in effect, a mediator among three independent services was not attractive when seen from his new perspective. Truman, a strong executive who desired greater control, agreed. The president's push for reform achieved success after Forrestal's departure. In August 1949 the National Military Establishment became the Department of Defense, with the three service secretaries subordinate to the second secretary of defense, Louis Johnson. A defense secretariat was established to aid in controlling the huge executive satrapy.⁴¹

The Navy and the proponents of a separate Air Force together ensured that the evolution of the National Defense Establishment would be toward coordination of the different services rather than toward unification. There was much practical logic in such coordination. In the field of medical supply a useful model already existed in the joint Army-Navy Medical Procurement Office, which dated from December 1945. Because the fledgling Air Force had as yet no separate medical service, the office purchased for all three departments and the Veterans' Administration, on the basis of contracts issued by them. A considerable amount of nuts-and-bolts work was under way in such areas as developing joint purchase descriptions and specifications, publishing a joint catalogue, and so forth. In November 1947 the services published joint procurement regulations.⁴²

⁴⁰Testimony of Chief of Staff General of the Army Dwight D. Eisenhower, 25 Mar 47, in U.S. Congress, Senate, Committee on Armed Services, *National Defense Establishment (Unification of the Armed Services): Hearings on S. 758*, 80th Cong., 1st sess., 18, 20, 25, 26 March and 1-3 April 1947, pt. 1 (Washington, D.C.: Government Printing Office, 1947), p. 107. See also Link and Coleman, *Air Force Medical Service*, pp. 166-234.

⁴¹Public Law no. 80-253, 26 Jul 47; Weigley, *History of the Army*, pp. 493-95.

⁴²Supply Division, OSG, Report of Activities, 1 Jul-31 Dec 47 and 1 Jul-31 Dec 48, files 319.1-2 (OSG, Annual Reports), HRB.

On behalf of the Air Force, the Army Medical Department continued for the time being to take responsibility for the storage and issue of medical supplies, for obtaining and assigning personnel, and for providing general hospital facilities. With the Navy's Bureau of Medicine and Surgery, cooperation made what Surgeon General Bliss termed "slow but steady progress." The services established similar physical standards, held interservice conferences, standardized some medical report forms, and agreed upon joint unification of hospital beds, especially in areas where one service or the other had none of its own available. For a time the two services attempted joint staffing of three naval facilities.⁴³

As 1947 ended, hospitalization, interservice cooperation, and economy remained linked concerns for the secretary of defense. At Forrestal's behest the service secretaries agreed on 25 November 1947 to set up a committee of the two surgeons general and the air surgeon, with a civilian as chairman, to study their hospitalization problems. The secretary's objective was to achieve greater efficiency and economy by improved utilization of hospitals and by coordinating medical plans and programs. The "civilian" selected to head the panel was Paul R. Hawley, a retired major general of the Army Medical Department.⁴⁴

Domineering, astute, and an extremely able administrator, Hawley had organized the medical service of the European Theater of Operations (ETO) during the war and later served as medical director of the Veterans' Administration. However, his work for the Committee on Medical and Hospital Services of the Armed Forces was limited by the demands of his civilian career and by his anger at what he saw as the obstructionism of the three surgeons general. Hawley did not accompany the committee on its travels and gradually withdrew from its work. He resigned in January 1949. After Hawley's departure General Bliss, acting as chairman, Rear Adm. Clifford A. Swanson, the surgeon general of the Navy, and Maj. Gen. Malcolm C. Grow, the air surgeon, carried out much of the work with the assistance of Rear Adm. Joel T. Boone, who served as executive secretary. Twenty-two subcommittees, whose members and staffs were drawn from the medical systems of the Army and the Navy, collected information and drew up reports.⁴⁵

The Hawley committee was diligent, the reforms it proposed limited and well within established military medical traditions. Members visited about 150

⁴³Quoted words from extract of Rpt, Section on Developments in the Medical Field, p. 23, Encl to Memo, Hartford to Chief, Control Office, Logistics Division, 10 Sep 48, HRB. See also Fourth Army, Fort Sam Houston, Texas, Annual Report of Medical Department Activities, 1948, p. 3, file 319.1-2 (Fourth Army) 1948, Box 4 (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB; extract from Memo, Col Paul I. Robinson, MC, Chairman, Subcommittee on Medical Department Personnel, to Chief, Joint Plans and Action Division, Office of the Director of Medical Services, OSD, 30 Nov 49, HSF (Robinson-1949), HRB.

⁴⁴Committee on Medical and Hospital Services of the Armed Forces, Office of the Secretary of Defense, "Report of the Committee on That Part of Its Assignment Relative to Programs for Hospitalization in the Armed Forces and for Improvement in the Utilization of Existing Hospital Facilities" (hereinafter cited as Hawley Report), 1949, pp. 1-3, file 337 (Draft Report of Committee on Medical and Hospital Services of the Armed Forces) Hawley-1949, HRB.

⁴⁵Extract from Memo (no. M-212-49), Office of Public Information, National Military Establishment, to the Press, 6 Jul 49, HSF (Public Information-1949), HRB. Hawley's career is treated extensively in Cosmas and Cowdrey, *The Medical Department: Medical Service in the European Theater of Operations*, forthcoming.

armed forces medical installations in the Western Hemisphere—general hospitals, naval hospitals, medical depots, laboratories, schools, some of the larger station hospitals, and even some dispensaries and clinics. One member spent six weeks covering Europe; another spent time in the Mediterranean and Middle East. The surgeons general recommended several improvements in service cooperation, to include opening joint centers for the diagnosis and treatment of special conditions (for example, neuropsychiatry at the U.S. Naval Hospital, Houston, Texas); conducting experiments in joint staffing; establishing a permanent committee to report to the secretary of defense; downgrading some hospitals to dispensaries; and closing other hospitals. With few exceptions, Secretary Forrestal accepted their proposals. Whether these changes met the needs of the time was another question. Organized within the military establishment, the committee had no real civilian member and simply assumed many things that the civilian profession viewed as disputable. Bliss himself vigorously opposed a unified medical service, which may have reflected the fact that Eisenhower, with his strong commitment to unification, had now retired to private life. Committee members saw military and civil medicine as radically different, requiring a far higher proportion of doctors in the services than in civilian life. The traditions of providing care to dependents of servicemen and allowing each armed service its own medical organization were not questioned.⁴⁶

Experience soon showed that even such basic, and to professional military people, axiomatic principles could become matters of public debate. Hawley spoke out in open forums, declaring his belief that the medical establishment could be reduced in numbers without impairing service. Pointing to vacant beds in military hospitals, he called for greater economy. He believed that the hospitals provided an excuse for training specialists, instead of drawing them, in case of war, from civil life, as was done in the past. ("In the ETO," he wrote, "I never hurt for clinical talent but I was constantly hurting for leadership of this talent half as good as the talent itself.") He believed and said that the military medical services should be unified completely at the general hospital level.⁴⁷

Hawley's attitude toward the work of the committee that bore his name was scathing. "It did not accomplish one damn thing," he wrote. "It was a waste of time and money." Its only real aim was to make cosmetic changes while seeking to preserve the status quo. "I say to you frankly that, in this Committee which I headed, there was a colossal display of bad faith." The surgeons general had followed a path of "noncooperation" in order to safeguard their own bureaucratic turfs.

⁴⁶Hawley Report, pp. 37–75, HRB; copy of Ltr, Hawley to Tracy S. Voorhees, Chairman, Committee on Federal Medical Services, 2 Feb 49, attached to *ibid.*; extract from Memo, James Forrestal, Secretary of Defense, to Secretaries of the Army, Navy, and Air Force, 21 Feb 49, sub: Programs for Hospitalization in the Armed Forces and for Improvement in the Utilization of Existing Hospital Facilities, HSF (Forrestal–1949), HRB; Ginn, "Of Purple Suits," p. 19; Link and Coleman, *Air Force Medical Service*, pp. 317–19.

⁴⁷Quoted words in this and following paragraph from copy of Ltr, Paul R. Hawley, Director, American College of Surgeons, to Col Floyd L. Wergeland, MC, 11 Apr 50, and copy of Talk, Hawley, Chief Executive Officer, Blue Cross and Blue Shield Commissions, to Citizens Committee for the Hoover Report, National Reorganization Conference, 12–13 Dec 49, sub: Better Federal

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Hawley's views reflected not only an acerbic personal style but also his new status in civilian medicine, his political conservatism, and his belief that any future war would be a worldwide struggle resembling those in which he had served. Nevertheless, such opinions from a man who had spent much of his life in uniform gave a taste of what civilians might conclude when they came to take a scalpel to military medicine. Bliss' own words to his staff suggested that he was metaphorically drawing his wagons into a ring. He had hoped, he said, to present a program for interservice cooperation that would "automatically eliminate too many civilians entering into the picture of the unification of the three medical services." He emphasized that "our only salvation in keeping this [unification process] 'medical' is for the three SG's to present to the Secretary of Defense something constructive and sound."⁴⁸ But the civilians were not to be so easily excluded.

From the angle of many physicians—their vision sharpened and sometimes embittered by their experiences during World War II—the established military proportion of about 6 doctors to 1,000 troops was grotesque. In civilian life 1 doctor to 1,000 or more persons, depending on location, was not uncommon. Believing that their colleagues in uniform should do only professional work, civilian physicians did not always appreciate the fact that a military doctor was an officer who had other duties to fulfill. The special requirements of the service—frequent physical examinations in a profession where physical condition was critical; routine hospitalization of men and women who, even for minor illnesses, could not be treated in barracks; treatment of troops scattered among many billets and on troopships; and a system of total and compulsory care, to include preventive medicine—seemed excessive to many civilians. Some American Medical Association members viewed the recruiting efforts of the services as a serious drain on a civilian profession already limited in numbers and, in consequence, judged their demand for more physicians to be unacceptable.⁴⁹

In the meantime, further proposals had surfaced through the president's Commission on Organization of the Executive Branch of the Government. Set up under the general direction of former President Herbert Hoover, the commission sought ways to bring greater efficiency and economy to the government by eliminating duplication and waste and by increasing centralization. Two of its task forces took aim at military medicine: the Eberstadt committee on national defense and the Voorhees committee on federal medical services. In the Eberstadt committee's view, "service estimates for their medical and dental needs are excessive"—"much higher in proportion to members than in civilian life." The committee questioned whether the Army's emphasis on professionalism might not lead to neglect of the field service and found the utilization of

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Medical Services, Hoover Task Force Report on Hospitalization (Voorhees Report) file, 1949, Box 5 (General Green's Office-Reference File), Accession no. 112-79-5, RG 112, WNRC.

⁴⁸SG Conference Notes, 3 Dec 47, HRB.

⁴⁹Copy of Memo, Isaac Cogan for The Surgeon General, DA, to Col St. John, Surgeon, First Army, 2 Nov 49, sub: Establishment of a Fixed Ratio of Medical Officers to Troop Strength for the Department of the Army, HSF (Cogan-1949), HRB. On physician ratios in civilian life, see Morris Fishbein, ed., *Doctors at War* (New York: Dutton, 1945), pp. 83-84.

doctors to be unsatisfactory. These failings, plus the assistance given the Veterans' Administration to help veterans and the care of dependents, contributed to what the task force termed "the apparent service shortage" of doctors. The Voorhees committee, accepting the inevitability of three separate medical services, recommended that the zone-of-interior hospitals of the armed forces be removed from military control and placed under a proposed civilian National Bureau of Health. Other suggestions included the complete unification of medical supply, giving a single service responsibility for hospitalization in each overseas area, reduction in dependent care, and curtailment of the armed forces postgraduate training programs. Specialists in the armed services were to receive residency training in nonmilitary federal hospitals.⁵⁰

Some of the ideas that had reached the commission through the reports of the Hawley committee were those of the surgeons general themselves. To others Bliss objected strongly. Control of hospitals was a sore point. In his view the Hoover commission in effect was seeking to relegate military medicine to field service, with no suggestion as to how professionals were to be brought into the Army under such conditions. In a private meeting with Secretary of the Army Kenneth C. Royall, Bliss protested that "this hospitalization program would so cripple the Army Medical Service as to make it completely second-rate—a Service of mediocrity."⁵¹ The attitude of Congress, where military control of hospitals and providing care for dependents were both popular, made it unlikely that the more extreme proposals would meet with approval. The emergence of a defense secretariat, on the other hand, opened the way for coordination in the interest of greater unity and economy within the military establishment itself.

Virtually all opponents of a unified medical organization had concurred on the need for a coordinating body to prepare recommendations on medical policy for the secretary of defense. As a result, on 9 November 1948, Forrestal set up the Armed Forces Medical Advisory Committee. The committee, headed by Charles P. Cooper, a New York businessman favored by the Hoover commission, consisted of thirteen civilians and the three surgeons general. But the new group soon found itself, like the secretary himself, somewhat stranded without an executive agency to carry out its recommendations. The surgeons general occupied a position that Gilbert and Sullivan would have loved to satirize. They

⁵⁰Quoted words as given in Memo, Col Paul I. Robinson, MC, Chief, Personnel Division, OSG, to Director, P & A Division, General Staff, Attn.: Lt Col E. L. Beauchamp, 3 Feb 49, containing comments on Summary of Report of the Eberstadt Committee, p. 1, tab 17, Colonel Robinson's Studies, RG 112, WNRC. See also copy of Memo, Lt Gen H. S. Aurand, GSC, Director of Logistics, to Gen J. Lawton Collins, Chief of Staff, USA, 25 Feb 49, sub: Staff Study on Formulation of Army Policy on Medical Service, HSF (Aurand-1949), HRB, and Committee on Federal Medical Services, United States Commission on Organization of the Executive Branch of the Government, *Federal Medical Services [Appendix O]: A Report With Recommendations*, January 1949, especially pp. 56–58, in Hoover Committee Reports and Appendices nos. 15–18, Law Library, Judge Advocate General, Department of the Navy. Ferdinand Eberstadt was an investment banker with a long record of government service. Tracy Voorhees was formerly a JAG officer assigned to the Office of the Surgeon General as a troubleshooter. See Voorhees' memoir, "A Lawyer Among Doctors," copy on file in CHA.

⁵¹MFR, Maj Gen Raymond W. Bliss, Surgeon General, DA, 5 Jan 49, sub: Conference With Secretary Royall, Hoover Task Force Report on Hospitalization (Voorhees Report) file, 1949, Box 5 (General Green's Office-Reference File), Accession no. 112-79-5, RG 112, WNRC.

gave the secretary of defense advice that, if accepted, each of them—as the secretary's technical staff officers—had to review and comment upon. For this reason, or to eliminate a source of obstruction, Forrestal removed them from the committee, making it wholly civilian.⁵²

In April 1949 the Cooper committee recommended to the new secretary of defense, Louis Johnson, that he form an organization with authority to establish policies and programs for the military medical services. Johnson created the Medical Services Division under Dr. Raymond B. Allen, a member of both the committee and the Hoover commission and president of the University of Washington in Seattle. The secretary then dissolved the Hawley committee and shifted the hundred or so military and civilian members of its subcommittees and staff to the new division. An Ohio doctor who had served in the Army Air Forces in World War II, Richard L. Meiling, succeeded Allen in October. A major general in the Air Force Reserve, he was an influential member of the American Medical Association as well.

Meanwhile, Congress had set up the Department of Defense, and a full-fledged Air Force medical service came into being in September, with its own surgeon general. At the end of the same month the Medical Services Division became the Office of Medical Services. Meiling was appointed director of medical services and assistant to the secretary of defense for medical affairs. After much bureaucratic turmoil the future of military medicine had taken shape. There were to be three separate medical services, coordinated at Department of Defense level, with unified procurement of supplies and, to some extent, integrated general hospitals.⁵³

The Personnel Problem Revisited

Throughout the period of unification trial and error (1947–49) the state of Medical Department personnel continued in its familiar patterns. In all corps save the Veterinary, substantial numbers of Regular Army officer slots went unfilled. The Army depended upon reserve officers on extended active duty to bear the greatest part of the burden, but all sources of medical officers together were inadequate to the requirements established by law, regulation, and tradition. The shortage of enlisted personnel also was severe. Budget-cutting deprived the department of critical numbers of its graded civilians, yet failure by the Army during 1947 to maintain its authorized strength meant that military personnel were lacking to man the hospitals. Ungraded civilians could not be hired to take up the slack, because most of the jobs such low-paid workers could handle were in the messes and wards. Skill remained at a premium and often was unobtainable. In mid-1947 some of the enlisted personnel at the Letterman,

⁵²It should be noted that one of the civilians was Hawley. See Rpt, Elsie LaMantia, 1 Nov 53, sub: Progressive Development of the Office of Assistant Secretary of Defense (Health and Medical) Within the Department of Defense, pp. 1–3, HSF (LaMantia–1953), HRB.

⁵³Ibid., p. 4; “Dr. Allen To Organize Medical Services Division,” *Bulletin of the U.S. Army Medical Department* 9 (August 1949): 695–96.

McCormack, and William Beaumont General Hospitals worked from sixty to seventy-two hours a week—a situation that did not encourage reenlistment.⁵⁴

In the Medical Corps, where skill was highest, conditions were the worst. Two events converged during 1948–49 to intensify all the difficulties of procurement: the impending release of most of the ASTPs; and, sparked by the Cold War, the revival of the Selective Service System in June, which brought into the Army substantial numbers of potential patients while Congress consistently declined to draft doctors to care for them. (Doctors might, of course, be drafted like other young men, but their extended education gave them an unusually good chance, by stringing deferments together with marriage, to avoid being called.) A special draft for doctors and dentists seemed the height of unfairness to the potential draftees, and the American Medical Association effectively opposed it. The attitude of the medical profession was a major disappointment to the Medical Department. Backing efforts during 1948 to get the doctor draft included in the law, the surgeon general declared that “the doctors will volunteer when the Draft breathes down their necks. . . .”⁵⁵

Defeat of the doctor draft provoked a new Greek chorus of warning and laments from military medical men and of skepticism from their civilian colleagues. In July 1948 Brig. Gen. George E. Armstrong, the deputy surgeon general, wrote the American Medical Association that “in my opinion the Medical and Dental situation relative to the Armed Forces is more critical than at any time in the last 25 years. All extensive data reveals that the supply of professional personnel . . . is deficient in both quality and quantity, and the present incentives to attract such personnel into the services are sorely inadequate.” Efforts to conserve personnel were “small in relation to total shortages,” and unless the procurement of officers could be greatly increased, “the success of supporting the Selective Service Act will be in great jeopardy.”⁵⁶

But many in the American Medical Association continued to doubt that staffing requirements were as the Army stated them. For its own part, the Medical Department waffled on a third-party inquiry into the question. Col. Paul I. Robinson of the Office of the Surgeon General proposed that the National Research Council of the National Academy of Sciences conduct an independent study of Army staffing needs, hoping that it might carry some weight with the medical profession. The OSG’s Resources Analysis Division rejected the suggestion on grounds that only the Army could fix its own requirements. However, Isaac Cogan, the division chief, admitted that only legislation could

⁵⁴Extract from Ltr, Maj Gen Raymond W. Bliss, Surgeon General, USA, to President, War Department Manpower Board, 30 Jun 47, sub: Personnel Authorizations for 30 June 1947; copy of Ltr, Bliss to Brig Gen George C. Beach, Commander, Army Medical Center, 11 Sep 47. Both in HSF (Bliss–1947), HRB.

⁵⁵Quoted words from SG Conference Notes, 28 Apr 48, HRB. See also Resources Analysis Division, OSG, Report of Activities, 1 Jan–30 Jun 48, file 319.1–2 (OSG, Annual Reports), and extract from Memo, The Surgeon General [Bliss], DA, to Brig Gen George E. Armstrong, Deputy Surgeon General, DA, 8 Jul 48, sub: Thoughts on the Medical Implications Resulting From the Present Draft Bill, HSF (Bliss–1948), both in HRB; and Paul I. Robinson, “About the Medical Department,” *Bulletin of the U.S. Army Medical Department* 8 (December 1948): 934–35 and 9 (February 1949): 104.

⁵⁶Extract from Ltr, Brig Gen George E. Armstrong, Deputy Surgeon General, DA, to Morris Fishbein, Editor, *JAMA*, 19 Jul 48, HSF (Armstrong–1948), HRB.

meet the Army's needs—that is, a doctor draft—and that “legislation is largely dependent upon the attitude of the civilian profession, specifically [the] A.M.A.” An impasse had been reached.⁵⁷

Meanwhile, the general Cold War draft brought about one hundred thousand new men into the Army during 1948–49. In consequence, thousands of physical examinations had to be given, and denunciations of civilian induction station physicians, a feature of most drafts, were heard again from the military reception centers. Recruits turned up with “easily diagnosed and patently apparent conditions,” including “valvular heart disease, gross overweight, epilepsy, . . . dislocations of major joints, loss of great toes, active tuberculosis, [and] gross and obvious deformities. . . .” Induction station doctors were quoted as having told such men: “You’ll be all right,” “When we want information we’ll ask for it,” “Next case,” “The Army will make a man of you,” and so forth. Reception centers then had to carry out disability discharge proceedings. The station hospitals bore the brunt of much of the work, despite severe shortages of manpower, including trained male ward attendants. The draft was not all bad news; medical ROTC enrollments skyrocketed during 1948–49, rising by 100 percent the first year, with a further jump of 81 percent the next. Overall, however, the work load had increased but the number of the most critical workers had not.⁵⁸

To its other expedients the Medical Department added the hiring of civilian doctors and dentists on contract; by the end of 1948, 285 were employed. But again, the numbers gained were out of proportion with the impending losses. The personnel problem grew, stretching across the world, like the Army. The European Command anticipated a loss of 270 out of 376 medical officers by mid-1949, and by the start of the year had “less than ten replacements . . . scheduled definitely.” Faced with a “critical shortage” of doctors, dentists, and nurses, the Far East Command reported that its attempts to recruit “met with small success.” By January 1949 the surgeon general had privately given up on the doctor draft, feeling that his organization would hurt itself with the medical profession without any real chance of obtaining such a law. Bliss declared to his staff that “anything we could do to aid the draft bill would be of no avail and prove most harmful. It is very, very doubtful as to whether this bill will ever be passed.” His advisers agreed. “Congress,” wrote Colonel Robinson, “in general,

⁵⁷Quoted words from extract of Memo, Isaac Cogan, Chief, Resources Analysis Division, OSG, to Chief, Personnel Division, OSG, 28 Sep 48, sub: Calculation of Medical Department Professional Personnel Requirements, HSF (Cogan–1948), HRB. See also copies of Memos, Col Paul I. Robinson, Chief, Personnel Division, OSG, to Chairman, Research and Development Board, OSG, Attn.: Col William S. Stone, 7 Sep 48, and Stone to Robinson, 23 Sep 48, subs: Calculation of . . . Requirements, HSFs (Robinson–1948) and (Stone–1948), HRB.

⁵⁸Station Hospital Camp Chaffee, Arkansas, Annual Report of Medical Department Activities, 1948, pp. 2 and 8–9 (source of quotations), file 319.1–2 (Station Hospital Camp Chaffee, Ark.), 1948, Box 130 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB. On civilian manning of induction stations, see SG Conference Notes, 30 Jun 48, HRB. See also Dental Division, OSG, Report of Activities of the Divisions of the Surgeon General's Office, 1 Jul–31 Dec 49, file 319.1–2 (OSG, Annual Reports), HRB; Station Hospital 6003 Army Service Unit, Fort Ord, California, Annual Report, 1948, p. 32, file 319.1–2 (Station Hospital Fort Ord, Calif.) 1948, Box 148 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; “Annual Reports of Medical Department Activities,” *Bulletin of the U.S. Army Medical Department* 9 (August 1949): 710–11.



DRAFTEES UNDERGOING PHYSICALS

can be said to be not 'draft-minded'. . . . Furthermore, the necessity for a draft would fall on us to prove and it is doubtful that it can be substantiated."⁵⁹

It was under these conditions that the military establishment turned to the civilian profession in a renewed effort to obtain volunteers. In response the American Medical Association through its journal launched an appeal, but with little success. In February 1949 Secretary Forrestal opened a so-called Moral Suasion Campaign at the suggestion of his advisory committee. The committee argued that "there is a possibility of obtaining sufficient physicians and dentists to meet the Services' requirements through an appeal to the professions for volunteers and that such appeal is a prerequisite to any resort to the compulsory induction of such personnel." This rationale was probably not taken literally even by its members, whose main concern was "averting the need for a draft." An ad hoc committee of the three surgeons general was established, to serve as the point of contact with the American Medical and the American Dental

⁵⁹First quotation from European Command, Annual Report of Medical Department Activities, 1948, Professional Services Branch, p. 5, file 319.1-2 (Headquarters, European Command) EUCOM-1948, Box 322 (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB; second quotation from FEC, Annual Report of Medical Department Activities, 1948, pp. 78-79, file 319.1-2 (FEC) 1948, Box 498 (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB; third quotation from SG Conference Notes, 10 Jan 49, HRB; fourth quotation from copy of Memo, Col Paul I. Robinson, Chief, Personnel Division, OSG, to The Surgeon General, DA, 29 Mar 49, sub: Recommended Position of The Surgeon General on Vital Subjects Brought to the Front by the Impending Shortage of Medical Officers, HSF (Robinson-1949), HRB.

TABLE 3—RESULTS OF THE MORAL SUASION CAMPAIGN, JUNE 1949

Service	Requests for Active Duty		Total
	1949	1950	
Army			
Medical Corps	163	17	180
Dental Corps	31		31
Air Force			
Medical Corps	39	3	42
Dental Corps	28		28
Navy			
Medical Corps	171	22	193
Dental Corps	46	2	48
Total	478	44	522

Source: Personnel Division, OSG, Report for the Annual Report of the Secretary of the Army, 1 July 48–30 Jun 49, p. 1, file 319.1–2 (OSG, Annual Reports), HRB. On 7 March 1949, 10,863 letters signed by the secretary of defense were sent by registered mail to ASTP- and V–12-trained doctors and dentists, inviting them to apply for commissions in one of the three service departments. Replies numbering 8,762 were received, with the above results.

Associations. It was to report through Cooper to Forrestal. The Office of Public Information, Office of the Secretary of Defense, was instructed to mount a public relations campaign aimed particularly at ASTPs who had escaped service. Every effort would be made to persuade such men that they owed a period of military duty to their country and should accept commissions.⁶⁰

Simultaneously, a new effort got under way to ensure that the old accusation of inefficient use of medical officers would no longer have substance. Secretary of Defense Forrestal, Secretary of the Army Royall, and Surgeon General Bliss sought for economies wherever they were to be found. The Army reduced bed authorizations in its hospitals. Because the inspector general had found no malassignment of medical officers under existing regulations, the regulations were revised, reducing the number of required physical examinations, limiting dependent care, and cutting back the number of boards and courts that medical officers were obliged to attend. The Veterans' Administration was asked to remove some veterans from Army hospitals and to take more Army patients into their own. To expand the manpower pool, the Medical Department rescinded age-in-grade restrictions on medical officers. Overall, by midyear the Army had reduced by 37 percent the ratio of doctors to troop strength, from 6 to 3.8 per 1,000. Tracy S. Voorhees, now an assistant secretary of the Army, found the cuts "so radical . . . that they are not in all respects desirable. They are . . . an austerity program necessitated by the present critical shortage of medical officers."⁶¹

⁶⁰First quotation from copy of Memo, James Forrestal, Secretary of Defense, to Secretaries of the Army, Navy, and Air Force, 14 Feb 49, sub: Establishment of Ad Hoc Committee for Recruitment of Medical and Dental Personnel, HSF (Forrestal–1949); second quotation from extract of Memo, Robert M. Beers, Armed Forces Medical Advisory Committee, OSD, to John H. Ohly, Office of the Secretary of Defense, 24 Jun 49, pp. 10–11, HSF (Beers–1949). Both in HRB.

⁶¹Quoted words from copy of Memo, Tracy S. Voorhees, Assistant Secretary of the Army, to Secretary of Defense, 2 Jun 49, sub: Army Conservation of Doctors, HSF (Voorhees–1949), HRB. See also copies of Memos, James Forrestal, Secretary of Defense, to Secretaries of the Army, Navy,

The cuts were real, but the side of the program aimed at recruitment produced no significant effect (*Table 3*). Few, it would seem, had ever believed it would. "Under the most optimistic expectations," wrote Dr. Robert M. Beers, a member of the committee on whose advice Secretary Forrestal had launched the program, "it was evident from the beginning that the Moral Suasion Campaign could not possibly close the gap between the doctors on hand and the Services' stated requirements." In all likelihood, the objective was to reduce the requirements rather than to gain new officers in large numbers. Noting that "at first glance" many of the duties performed by medical officers had appeared to civilian advisers of the secretary to make no direct contribution to military effectiveness, Beers admitted that "most . . . were specifically authorized by law or rooted in tradition." Pointing with satisfaction to the reduction of service requirements from eighty-eight hundred to seventy-five hundred physicians, he termed the new figure "a minimum estimate . . . adequate to serve the needs of the fighting services under the present conditions." Those conditions, of course, featured garrison duty in a time of peace.⁶²

However, the Medical Department, following release of the officers scheduled for departure, could not meet the new goals any more than the old. The loss of twenty-five hundred ASTPs cut sharply into the supply of company-grade officers who would be so important in time of war.

The department resumed its customary search, employing both new and old expedients. Congress again voted incentive pay and found money for increased numbers of contract doctors, dentists, and nurses. The Army gave the surgeon general direct access to the chief of staff, and medical officers to their respective commanders, raising the priority of the problem, if nothing else. Medical and dental officers were given a variety of perquisites; were favored in the assignment of quarters; and, in overseas duty, were authorized to have their dependents accompany them. When the surgeon general sought to employ still more civilian doctors and dentists, however, an Army-level staff study rejected the idea, in part because "further encroachment upon military medicine by civilian medicine may well threaten the very existence of the Medical Department."⁶³

Secretary of Defense Johnson continued to press for greater cooperation among the services as a means to the end of greater economy. At his insistence, conveyed through Medical Services Director Meiling, and much against the will of Surgeon General Bliss, four of the Army's general hospitals were closed in the

and Air Force, 1 Mar 49, and Kenneth C. Royall, Secretary of the Army, to Secretary of Defense, 21 Mar 49, subs: Reduction of Medical Work Load, HSFs (Forrestal-1949) and (Royall-1949). On dependent care, see copy of DF, Lt Col C. A. McAllister, MSC, Chief, Operations Branch, Medical Plans and Operations Division, OSG, to Plans and Projects Office, OSG, Attn.: Lt Col Scheele, 18 Feb 49, sub: Hospitalization and Evacuation Policies, HSF (McAllister-1949). All in HRB.

⁶²Extract of Memo, Beers to Ohly, 24 Jun 49, pp. 8-10, HRB.

⁶³Quoted words from Special Plans Branch, Medical Plans and Operations Division, OSG, Report of Activities, 1 Jul-31 Dec 49, file 319.1-2 (OSG, Annual Reports), HRB. See also Public Law no. 81-351, 12 Oct 49; extract from Surgeon's Circular Letter 4, no. 10, Medical Section, FEC, 1 Oct 49, HSF (FEC Circular Ltr-1949), HRB; Murphy General Hospital, Annual Report of Medical Department Activities, 1949, p. 45, file 319.1-2 (Murphy General Hospital) ZI-1949, Box 87 (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB; Personnel Division, OSG, Report for the Annual Report of the Secretary of the Army, 1 Jul 48-30 Jun 49, pp. 7-8, file 319.1-2 (OSG, Annual Reports), HRB.

TABLE 4—BOARD-CERTIFIED REGULAR ARMY MEDICAL OFFICERS,
MARCH 1950

Specialty	Number*
Internal Medicine	52
Radiology	28
Preventive Medicine and Public Health	23
Surgery	23
Orthopedic Surgery	15
Pathologic Anatomy	12
Dermatology and Syphilology	11
Psychiatry	9
Otolaryngology	9
Pathologic Anatomy and Clinical Pathology	8
Urology	7
Psychiatry and Neurology	6
Obstetrics and Gynecology	5
Ophthalmology	5
Pediatrics	3
Physical Medicine	3
Clinical Pathology	3
Anesthesiology	2

*One officer additionally was qualified in each of the following: internal medicine and cardiology; internal medicine and pediatrics; neurology; preventive medicine, public health, and clinical pathology; ophthalmology and otolaryngology; plastic surgery; surgery and thoracic surgery. There was no board-certified neurosurgeon in the Regular Army component of the Medical Department.

spring of 1950. Amid many losses and retreats, the surgeon general and the secretary of the Army looked forward to the time, two years hence, when the postgraduate programs would begin to bring in their full harvest. Predicting that the Army Medical Department would find in its residents the mainstay of its future personnel needs, the secretary foresaw that the shortage of Medical Department officers would reach its peak in 1950 and thereafter improve.⁶⁴

But the postgraduate programs were also under pressure as teaching hospitals were closed. In May General Bliss announced the “streamlining” of the program of medical education, the most expensive aspect of the professionalization drive in terms of money and manpower. The Medical Department reduced the number of civilian internships from 300 to 200 and of military internships from 199 to 150. The number of military residencies was cut by 245, and civilian residencies were abolished. By this time the department could boast of specialists in a variety of fields. However, it still showed disconcerting vacancies in a few fields and, by cutting back on the program, endangered its effort to appeal to young men of promise (*Table 4*).⁶⁵

As the fifth anniversary of V-E Day passed, a complex and distinctive part of the Medical Department’s history drew insensibly to a close. Obligated to meet the needs of a greatly expanded peacetime Army without adequate resources, the organization had remade itself in the hope of upgrading the skills of its officers and attracting a sufficient number of young physicians into its ranks. In

⁶⁴Special Plans Branch, Medical Plans and Operations Division, OSG, Report of Activities, 1 Jul–31 Dec 49, pp. 148–49, HRB.

⁶⁵Surgeon’s Circular Letter 5, no. 6, Medical Section, FEC, 1 Jun 50, pp. 3–4, file 300.5 (Circular Letters) FEC, HRB.

the process it had become a different organization—more professional, more expert, and perhaps less ready for field service. Reorganization expanded the role of medical administrators, made a place in the Regular Army for specialists in allied fields, and gave the department's female members more adequate recognition of their worth. Its relations with the civil profession of medicine also were transformed, as it drew closer to the specialist-oriented model popular in the profession as a whole. In many respects, this evolution benefited its relations with the rest of the profession. The department had many friends in civilian medicine. It continued, as it had during the war, to draw upon civilian consultants, and it won distinguished advocates near the pinnacle of American medicine.

Yet the profession's suspicions of the military were not eliminated, and the practical interests of doctors and dentists were clearly against military service for most. The personnel problem, for reasons that went deep into American society, proved fundamentally insoluble. The department lived by expedients. The health of the Army was excellent, the hospitals that remained continued to operate, and the feeling in the Office of the Surgeon General was that the department could make do until the residents had completed their training. The time of most severe depletion, everyone agreed, would come about June 1950.

CHAPTER 2

Japan and Korea After V-J Day

While the surgeon general struggled with the problems of the Medical Department at large, medics in the Western Pacific faced challenges of their own. Here 1945 had brought a series of especially drastic changes in fortune. Early in the year Admiral Chester W. Nimitz' forces aimed a powerful thrust at the large, heavily defended island of Okinawa, south of the main Japanese islands. Their objective was to conquer a staging area for the anticipated assault on Japan. Between April and July, fierce and bloody fighting marked by grim casualty figures on both sides ended in an American victory. Meanwhile, V-E Day had brought the end of the conflict against Germany, with resulting shifts in personnel and supplies. In August, as a massive buildup for the invasion got under way, news arrived that indicated that the war would soon be over. Two atomic bombs leveled the Japanese cities of Hiroshima and Nagasaki, the Russians entered the war, and on 15 August the Japanese government sued for peace. V-J Day was 2 September 1945.¹

With stunning suddenness, the armed array gathering in the Western Pacific lost its purpose. In the course of a few months most of its millions of men and women headed for home, their military service soon to be ended. The troops who remained became occupiers of the land they had expected to conquer and, as the custodians of peacetime bases, stored or destroyed the mountains of war materiel left over from the war. In Japan, the United States emerged as the dominant power of the Occupation, and General of the Army Douglas MacArthur, as supreme commander for the Allied Powers, reigned as virtual proconsul in Tokyo. American soldiers gave direction to the civil government and a population of about 73 million people.

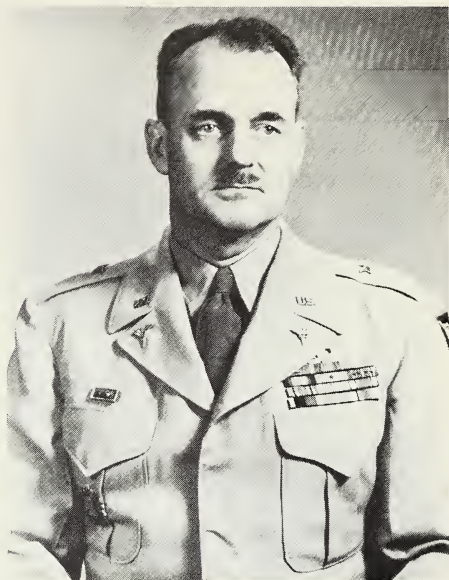
At the same time, Japan's former sphere of influence fell to the victors. Korea, for thirty-five years a Japanese colony, hailed as liberators the Russian forces that entered from the north and, later, the American forces that landed in the south. The two wartime allies divided the country along a line their diplomats had previously agreed upon, the 38th Parallel of north latitude. The United States had taken on another weighty responsibility. Until mid-1950, how-

¹For a history of the Medical Department in the war against Japan, see Condon-Rall and Cowdrey, *The Medical Department: Medical Service in the War Against Japan*, forthcoming. On Okinawa, see Roy E. Appleman et al., *Okinawa: The Last Battle*, United States Army in World War II (Washington, D.C.: Historical Division, Department of the Army, 1948).

ever, the true depth of the nation's involvement in Korea was either little understood or seldom admitted. Japan was another matter. Here the United States had clear if grandiose aims and undertook them with a will.²

American policy aimed at transforming Japan into a democratic and peaceful nation that would no longer represent a military threat to the United States or to its allies in the Far East. From the beginning, however, the defeated nation required help and redirection in many spheres other than the political. For medical authorities, the intimate contacts that the Occupation would inescapably bring between troops and civilians meant that the health of the latter was of great importance. Both humanitarian considerations and the practical need to prevent unrest and promote democratic government by demonstrating concern with health and welfare pointed in the same direction. An occupation policy without a sound medical policy was meaningless.

Quickly MacArthur's rule took a form that divided medical responsibility into two spheres, care of the civilian population and care of the troops. Advising him on medical matters and establishing medical policy for the occupying forces was the surgeon who headed the medical staff section of the military command. As military commander in chief, MacArthur gave orders to Americans in the Western Pacific through the military structure known during 1945–46 as Headquarters, United States Army Forces, Pacific (USAFPAC), and, after 1 January 1947, as General Headquarters, Far East Command (FEC). Two field armies were in the region, the Sixth and the Eighth, but the disestablishment of the former left a single major Army command in the Japanese islands. Other organizations subordinate to the military command were an air and a naval command, a headquarters and service group, and area commands for the Philippines, Marianas-Bonins, and Ryukyus. Parallel to the military structure was the General Headquarters, Supreme Commander for the Allied Powers (SCAP), whose responsibility was to guide the Japanese government. SCAP's medical staff unit



BRIG. GEN. CRAWFORD F. SAMS
(1948 photograph)

²For background information and general interpretations of the period, see Louis J. Halle, *The Cold War as History* (New York: Harper & Row, 1967), pp. 1–41, 89–98, 190–201; William Craig, *The Fall of Japan* (New York: Penguin Books, 1979); George M. McCune, *Korea Today* (Cambridge, Mass.: Harvard University Press, 1950); Edwin M. Martin, *The Allied Occupation of Japan* (Stanford: Stanford University Press, 1948); Robert A. Fearey, *The Occupation of Japan, Second Phase: 1948–50* (New York: Macmillan, 1950); D. Clayton James, *The Years of MacArthur: Triumph and Disaster, 1945–1964*, vol. 3 (Boston: Houghton Mifflin, 1985), pp. 276–79.

was the Public Health and Welfare Section, headed for six years (1945–51) by Col. Crawford F. Sams.³

Public Health and Welfare

A trim man of aggressive mien, Sams did not lack for work. Japan at war's end was an epidemiologist's nightmare. In part, the nation's problems were a carryover from prewar conditions. Japan was a nation with a large population housed on constricted islands with meager resources. Until the mid-nineteenth century the life of its people was medieval, rich in culture and tradition but poor in scientific knowledge. Western medicine was brought to Japan by Dutch traders, and once the national policy of isolation had ended, a medical officer of the Prussian Army helped to turn Japan toward the German tradition, with its heavy emphasis on research. As the nation moved at breakneck speed into the modern world, some Japanese researchers contributed brilliantly to the development of modern medicine. Yet despite such achievements and the striking modernity of parts of pre-World War II Tokyo, public health remained for the mass of the people a primitive affair. Manuring with human wastes reflected the lack of alternative fertilizers and helped to spread enteric diseases. Malaria, typhus, and encephalitis were endemic. Medical practitioners were ample in numbers but, in great measure, ill-trained; bureaucratic practices that subjected scientists to administrators ignorant of medicine stifled the public health organization. Reporting of diseases was spotty, and statistics on morbidity—essential to successful countermeasures—were not collected properly.⁴

A generation of war had made these conditions incomparably worse. The demands of the military had depleted civilian health resources. Merciless bombing destroyed cities, disrupted water mains, and leveled over a thousand hospitals. Sams on his first walk through Yokohama saw “only ashes, literally miles of ashes interspersed with tall isolated chimneys and steel safes.”⁵ Hospitals that had survived the onslaught were filthy and almost empty of patients, whom

³Thomas B. Turner, “Japan and Korea,” in *Civil Affairs/Military Government Public Health Activities*, Medical Department, United States Army, ed. Ebbe Curtis Hoff (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1976), pp. 662, 669–71; USAFFE and EUSAR, “Logistics in the Korean Operations,” vol. 1, p. 2, Ms no. 8–5.1A AZ, RG 319, MMHB. On creation of the Far East Command, see United States Army Forces, Pacific (hereinafter cited as USAFPAC), Annual Report of Medical Department Activities, 1946, p. 2, file 319.1–2 (USAFPAC, Chief Surgeon's Report, 1946), Box 496 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB. On the mission of SCAP's medical section, see Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied Powers (hereinafter cited as SCAP), *Public Health and Welfare in Japan, 1948* (FEC Printing Plant, 1949), pp. 5–6, LIB. Despite the existence on paper of a headquarters called United States Army Forces, Far East, no actual separate organization comprehending the various Army commands existed. All commands, regardless of service, reported to the Far East Command.

⁴Ilza Veith, “On the Mutual Indebtedness of Japanese and Western Medicine,” *Bulletin of the History of Medicine* 52 (Fall 1978): 383–409; *Civil Affairs/Military Government Public Health Activities*, pp. 668–69, 673–75, 681; John Z. Bowers, *When the Twain Meet: The Rise of Western Medicine in Japan* (Baltimore: Johns Hopkins University Press, 1980).

⁵Crawford F. Sams, “Medic,” 2 vols, 2:349, LIB. See also *ibid.*, 2:378.

hospital personnel had removed fearing that the conquerors would massacre them.

The lot of the people was grim.⁶ In Tokyo, Sams picked his way through subway tunnels where thousands of the homeless lay in fetid darkness, many dying of smallpox, typhoid, and typhus. Some seventy-eight thousand sick and wounded veterans needed care. Meanwhile, great movements of population—some 7.3 million either entered or left Japan by the end of 1948—threatened the spread of disease. While the war went on, Chinese, Formosans, and Koreans entered Japan for various reasons, hundreds of thousands of them as forced laborers. Japanese armies and civilians expanded overseas, and then, when peace came, their property seized and their lives endangered by those they had ruled, returned again to their former homes. Medics faced a land filled with tired, hungry and homeless people who were already seeded with diseases, both homegrown and exotic.

SCAP attempted to head off trouble, issuing on 22 September a comprehensive directive to the Japanese government demanding surveys of hospital facilities and establishing a system of weekly communicable disease reports by prefecture. All wholesale civilian and military stocks of medical, dental, veterinary, and sanitation supplies, plus military foodstuffs, were released and distributed through the Japanese government wherever needed most. With Navy aid, quarantine controls were imposed on all ports. The Army granted assistance from its own supplies, contributing four thousand boxes of medical goods diverted from the Philippines in response to an urgent call from SCAP. The supreme commander also dispatched 12 tons of supplies to the International Red Cross relief effort at Hiroshima. Colonel Sams surveyed the available Japanese professionals, finding that numbers were satisfactory—some thirty-nine thousand physicians plus another twenty thousand with the armed forces, waiting to be demobilized. However, he was to write a few months later, “my greatest handicap is not quantity but lack of quality in the Japanese professional people. . . .” SCAP likewise searched out the available supplies of food, finding that production of meat was about 10 percent of normal and that of milk at a standstill, except on the northern island of Hokkaido. Rice and seafood, the traditional main reliance of the Japanese diet, were available, but in 1946 nutrition surveys showed, according to Sams, that city dwellers “were near the danger point of mass starvation. . . .” Caloric intake was low, at 1,034 to 1,325 calories, and the rations issued by the government did not become entirely adequate until 1949.⁷

⁶Unless otherwise indicated, materials on public health are from General Headquarters, Supreme Commander for the Allied Powers, “History of the Nonmilitary Activities of the Occupation of Japan, 1945 Through December 1950,” vol. 8, “Public Health, September 1945 Through December 1945” (hereinafter cited as SCAP, “Occupation of Japan: Public Health”), Ms no. 8-5 AA 7 V 5, RG 319, MMHB. On numbers of repatriates, see extract from Ltr, Col Crawford F. Sams, Chief, Public Health and Welfare Section, SCAP, to Brig Gen S. Bayne-Jones, Deputy Chief, Preventive Medicine Section, OSG, 4 May 46, HSF (Sams-1946), HRB, and SCAP, *Public Health and Welfare in Japan, 1948*, pp. 66-68, LIB. A useful summary on public health administration is Crawford F. Sams, “American Public Health Administration Meets the Problems of the Orient in Japan,” *American Journal of Public Health and the Nation's Health* 42 (May 1952): 557-65.

⁷First quotation from extract of Ltr, Sams to Bayne-Jones, 4 May 46, HRB. Second quotation from Sams, “Medic,” 2:428, LIB. See also SCAPIN 48, Memo, Lt Col Harold Fair, Assistant

Thrusting aside all other problems were epidemic outbreaks in the fall and winter of 1945 (*Table 5*). In October typhus was found to be widespread in Hokkaido. The disease had begun among Korean coal miners and other laborers. Crossing the Tsugaru Strait to the main island of Honshu as they headed toward home, these unfortunates spread typhus through the Japanese heartland. Simultaneous outbreaks in other parts of Japan were traced to repatriates arriving from mainland Asia. Osaka was especially hard-hit, and cases were reported in many major cities, including Tokyo. Caused by organisms called rickettsiae, and carried by lice, epidemic typhus brought high fever, delirium, and prostration often ending in death. The disease is classically associated with famine, overcrowding, and the aftermath of war.

All circumstances favored its spread in Japan, as the onset of winter caused louse-infested people to huddle together for warmth. Centers of infection developed wherever people mingled—in jails, detention centers, dormitories, theaters, orphanages, public baths. Railroad stations were foci of the disease. Here, vagrants sought shelter, living in filth. Because the cities were destroyed in large part, the government forbade any but essential workers to return to them until services had been restored, and in consequence jam-packed trains carried tens of thousands seeking food and work every day. In Sams' opinion, typhus became a contact disease on the trains, spreading like influenza as commuters breathed in rickettsiae from louse feces in their neighbors' clothes and hair.⁸

Essentially, Sams' response was to combine American medical supplies and know-how with Japanese manpower, watched over and directed as far as possible by his own personnel. The United States of America Typhus Commission provided overall guidance. SCAP ordered the Japanese government to begin an intensive immunization program, using American-supplied vaccine, in the stricken areas. In December 50,000 pounds of DDT arrived by air from the United States. Military commanders in Japan, under orders from MacArthur's headquarters, kept supplies moving.

Drawing on his professional experience in the Panama Canal Zone and the Middle East, Sams built up an organization targeted at vector control—that is, destruction of the insect and other carriers of disease. Americans served as prefecture public health officers. U.S. military personnel provided instruction and supervision to Japanese insect control teams. Each team had six men and

(Continued)

Adjutant General, for SCAP to Imperial Japanese Government, 22 Sep 45, sub: Public Health Measures, file 300.6 (SCAPINS 1-100), Box 434 (Mail and Records Branch, Operations Division, Adjutant General's Section, SCAP, 1945-46), RG 331, MMFB; extract from General Headquarters, Supreme Commander for the Allied Powers and the Far East Command, *Selected Data on the Occupation of Japan*, p. 31, HSF (Occupation of Japan), HRB; extracts from General Headquarters, Supreme Commander for the Allied Powers (hereinafter cited as SCAP), *Summation of Non-Military Activities in Japan*, no. 1, September-October 1945, pp. 5-11, and no. 2, November 1945, p. 19, HSF (SCAP Summation, 1945-46), HRB. On the problems of getting a hospital going again, see Richard B. Berlin, "Impressions of Japanese Medicine at the End of World War II," *Scientific Monthly* 64 (January 1947): 41-49.

⁸SCAP, "Occupation of Japan: Public Health," p. 29, RG 319, MMHB; Ltr, Sams to Bayne-Jones, 6 May 46, HRB. On typhus, see Arthur Hurst, with the cooperation of H.W. Barber et al., *Medical Diseases of War*, 4th ed. (Baltimore: Williams and Wilkins, 1944), pp. 235-60; Hans Zinsser, *Rats, Lice and History: Being a Study . . . Which . . . Deals With the Life of Typhus Fever* (New York: Blue Ribbon Books, 1935).

TABLE 5—COMPARATIVE CASE RATES^a OF MAJOR DISEASES DURING THE OCCUPATION

Disease	1945	1949	Percent Decrease
Diphtheria	122.8	18.0	85.3
Dysentery	138.0	29.2	78.8
Typhoid	82.9	7.9	90.5
Smallpox	2.3	0.2	91.3
Typhus	3.5	0.1	97.1
Tuberculosis ^b	571.2	...
Death rate	280.0	168.8	39.7

^aPer 100,000 population.

^bNo data prior to 1945.

Source: Extract from General Headquarters, Supreme Commander for the Allied Powers and the Far East Command, *Selected Data on the Occupation of Japan*, p.31, HSF (Occupation of Japan), HRB.

proved able to oversee twenty-five urban blocks, or about 5,000 people. Demonstration units spread to health workers exact information on what Sams wanted, while he maintained overall control through the Japanese central government. The residual killing power of DDT made the spraying of ships and railroad cars a long-term solution to a basic source of infection. The control teams also disinfected people; in heavily affected areas they might dust and delouse the whole population of a city block, of several blocks, or even of an entire ward. In all, about 17 million were dusted and 5.3 million vaccinated against typhus. By the end of April the disease was almost wiped out in Osaka, where 40 percent of the cases had occurred. In the first half of 1946, 29,939 cases were reported; in the second, only 1,202. At no time through 1950 did the incidence of typhus exceed 1,000 cases. With every circumstance ripe for a major calamity, the disease had been contained.⁹

In large measure, as Sams recognized, the victory over typhus, like the epidemic itself, reflected the conditions of postwar Japan. Knowledgeable physicians, working through the military government and the civilian ministry, could impose nationwide discipline to fight disease. "We have no comparable ministry or cabinet [post] in America," he wrote, "or any program as comprehensive in the United States." For the time being, the entire Japanese nation was amenable to the kind of health discipline that at home belonged to the armed services alone. The work expanded steadily, drawing on the pool of educated or educable labor in which Japan was rich. By the summer of 1947 nine thousand teams, employing 54,000 people, were at work.¹⁰

Other epidemic outbreaks underlined the necessity for action. One was typhoid, always a danger when public sanitation breaks down and, like typhus, an

⁹SCAPINS 331 and 368, Memos, Col H. W. Allen, Assistant Adjutant General, for SCAP to Imperial Japanese Government, 21 and 29 Nov 45, subs: Prevention and Control of Typhus Fever in Japan, file 300.6 (SCAPINS 301-400), Box 434 (Mail and Records Branch, Operations Division, Adjutant General's Section, SCAP, 1945-46), RG 331, MMFB. See also extracts from Ltrs, Sams to Bayne-Jones, 6 May 46, and to Lt Col Stanley J. Leland, Acting Director, Civil Public Health and Nutrition Division, OSG, 21 Feb 46, HSF (Sams-1946), HRB.

¹⁰Quoted words from extract of Ltr, Sams to Leland, 21 Feb 46, HRB. See also SCAP, *Public Health and Welfare in Japan, 1948*, p. 63, LIB. On aerial spraying versus ground control, see Joseph E. Webb, Jr., "Problems of Insect Control," *United States Armed Forces Medical Journal* 3 (April 1952): 641-46.

ailment favored by postwar chaos and disruption. The autumn of 1945 saw the highest incidence on record in Japan. Urged on by SCAP, the government reacted with an environmental cleanup and an immunization program that reached some 20 million people. Typhoid rates declined by a fourth in 1946 and thereafter fell precipitously to less than a tenth of the 1945 figures. In April 1946 another deadly enteric complaint threatened briefly as cholera showed up among repatriates coming by ship from southern China. Illegal entrants also carried the disease into Japan. Again SCAP and the Japanese Ministry of Health and Welfare launched an inoculation program in the danger areas, reaching more than 36 million people during the summer and fall. Improved sanitation, however, was more important than the vaccine, which did not prevent transmission of the disease.¹¹

For a time, smallpox presented a more serious danger than either typhoid or cholera—in part, ironically, because the government had made a real effort to prevent the disease before the war. When its program of compulsory vaccination lapsed during the conflict, a large part of the population was left in a dangerous condition, protected neither by vaccine nor by natural contact with smallpox. Historically, such virgin populations have suffered terribly from the disease. Incidence rose throughout the war. In 1946 an epidemic flared, causing 17,000 cases before increased production of vaccine and the emergency mass immunization of virtually the entire population—possibly the largest such campaign ever undertaken—ended the outbreak.

Far more tenacious was the slow and unspectacular killer tuberculosis. The leading cause of death in Japan since 1934, tuberculosis gained strength from the malnutrition, crowding, exposure, and shortages of fuel and clothing brought by the war. In 1945 the death rate reached an alarming 280 per 100,000 population. In this case, however, the war only reinforced a long-standing perception that Japan—compared to her industrial counterparts—was a backward nation. In late 1946, as soon as the more pressing dangers of the postwar epidemics abated, SCAP moved against the killer disease. The Ministry of Health and Welfare launched a nationwide control program. Radio, the press, and posters made tuberculosis a subject for open discussion. Nationwide testing caused morbidity rates to soar by revealing for the first time the dimensions of an enormous, unresolved problem. Hospitals and sanatoria expanded and beds for patients multiplied. In 1949 a new antibiotic, streptomycin, proved its effectiveness in many cases. By 1950 the death rate had fallen to 146 per 100,000. But despite all efforts, tuberculosis remained the leading cause of death, and more than half a million victims were undergoing treatment.

Other durable ills were closely entwined with Japanese habits and lifestyle. At the end of the war almost half the population was infested with hookworms, roundworms, or both. Dysentery, diarrhea, and gastroenteritis were likewise common, causing about seventeen thousand deaths every year. For obvious reasons, such ills had spread more widely during wartime. In 1945 the dysentery case rate stood at 138 per 100,000 population compared to a prewar range of 70

¹¹This and the following two paragraphs are based on SCAP, "Occupation of Japan: Public Health," pp. 48–49, 56–61a, and app. 8, RG 319, MMHB.

to 105. Using Sams' system of teams, a vigorous national cleanup began, much of it carried out at the local and municipal levels. Positive results began to appear as early as 1946, and by 1948 the dysentery rate had fallen to about 18 per 100,000. But national habits were not easily changed. Fertilizing with night soil continued. In 1947 the Far East Command noted that much of Tokyo was still served by the "honey-bucket system," some of the night soil being shipped back to farm villages for sale. Shortage of other fertilizers made change difficult. Similarly, Japanese dietary habits baffled public health officials, for many foods were eaten raw, or lightly cooked, and were served in a multitude of small restaurants and street stalls. By 1949 disease rates had begun to climb again. Improved treatment reduced fatalities, yet the mortality rate also remained high, and by 1951 the number of cases was three and a half times as great as in 1946. As so often happens, public health officials found it easier to halt killer epidemics than to eradicate deeply entrenched endemic ills.¹²

Likewise, encephalitis fell in 1949 but rose again thereafter. Malaria responded better, dropping by 1950 to about one-tenth of its 1947 rate, and diphtheria, in the face of widespread inoculation, declined by over five-sixths during 1945-50.¹³

Overall, the revolution in health care that SCAP had launched and the Japanese government had carried out showed impressive results. Public health legislation set the new policy firmly in the nation's statute law. Japanese expenditures on health and sanitation rose from about 30 million yen in 1945 to 1,167 million in 1950. Slower and less visible than the sanitation teams and propaganda campaigns, but even more important in the long run was a basic reorganization of the medical and nursing professions. An American education mission aided SCAP and Japanese educators in a thoroughgoing reform of the medical schools. The health care professions were freed from the control of government bureaus and reshaped into professional organizations on the American model. The status of Japanese nurses, who were looked upon as little more than servants before the war, improved markedly. The professional training of nurses was standardized, and nursing texts were translated from English. Facilities, too, bore the mark of the Occupation. SCAP abolished military hospitals, transferred them to civil management, and encouraged the government to enact compulsory standards to improve them. Japanese laboratories modernized their production of biologics. Community health centers were set up throughout the islands, as health teaching and care reached out to the whole population.

Medical contributions to the success of the Occupation were substantial in preventing unrest, in demonstrating the new regime's practical concern for the Japanese, and not least in improving the health of the people among whom they lived. Japan by the early 1950s was not a promised land of health, but it was on its way to becoming a modern nation in health care and preventive medicine. During the period 1947-50 life expectancy increased from fifty to fifty-eight

¹²*Ibid.*, pp. 38a-40, RG 319, MMHB. Quoted words from FEC, Annual Report of Medical Department Activities, 1947, app. 1, p. 1, file 319.1-2 (FEC) SWPA-1947, Box 497 (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB.

¹³SCAP, "Occupation of Japan: Public Health," pp. 35, 38, 45, RG 319, MMHB.

years for men and from fifty-four to sixty-two years for women. General Sams left for home in 1951 and retired in 1955, hailed by the press for "one of the great recent public health achievements," which he explained as "just a matter of organization."¹⁴

Care of the Troops

Because armed resistance by the Japanese still seemed a possibility in August 1945, large numbers of American troops entered the conquered nation in the first few months of peace. With them came nearly all of the field medical units originally scheduled to accompany the army of invasion. The Sixth Army surgeon moved with the Army headquarters into Kyoto, while the Eighth Army surgeon, Brig. Gen. George W. Rice, took up occupation duties in Yokohama.

As medics poured into Japan, they found extraordinarily varied tasks to perform. Tens of thousands of Allied prisoners and internees, many in deplorable physical shape, needed care. American troops celebrated victory in immemorial fashion. Almost immediately they found means to visit prostitutes, and a lively venereal disease problem began to take shape. Some obtained wood alcohol from Japanese fuel dumps and used it to enhance brandy and saki; fifteen died. Two medical officers of the 1st Cavalry Division had a unique experience shortly after the unit entered Tokyo in September. Former Prime Minister Hideki Tojo attempted to kill himself, and the officers were called in to save the aging statesman for later trial and the gallows. Meanwhile, under Brig. Gen. Guy B. Denit, Surgeon, USAFPAC, preparations had begun for a medical study of the aftereffects of the atomic bombings of Hiroshima and Nagasaki. Later the Army team joined forces with Japanese scientists and with a group sent by the Manhattan District to form the Japan-U.S. Joint Commission for the Investigation of the Effects of the Atomic Bomb in Japan. The commission's studies were to lay the groundwork for all subsequent efforts to comprehend the effects, including the medical effects, of atomic weapons.¹⁵

¹⁴Quoted words from "A Good Man Gone," *Newsweek*, 8 Aug 55, p. 46. See also SCAP, "Occupation of Japan: Public Health," pp. 102, 134, 146, 166, RG 319, MMHB; extract from SCAP, Summation of Non-Military Activities in Japan, no. 3, December 1945, HSF (SCAP Summation, 1945-46), HRB; *Civil Affairs/Military Government Public Health Activities*, p. 681.

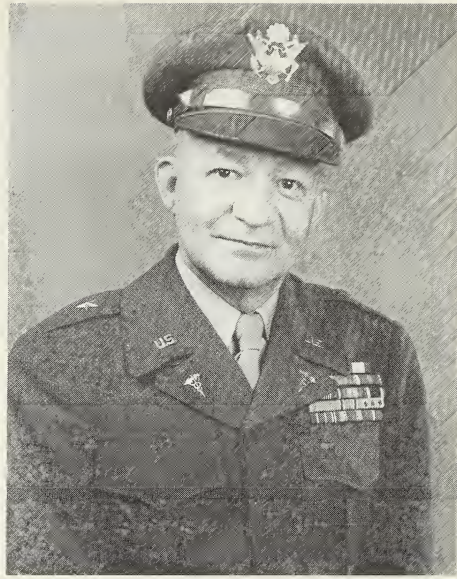
¹⁵Craig, *Fall of Japan*, pp. 316-21; United States Army Forces, Pacific (hereinafter cited as USAFPAC), Report of ETMD, October 1945, pp. 19-21, file 350.05 (USA Forces, Pacific, Oct 45), Box 72 (USA Forces, Pacific, Aug-Dec 45), Entry 54B, RG 112, MMFB; Committee for the Compilation of Materials on Damage Caused by the Atomic Bombs in Hiroshima and Nagasaki, ed., *Hiroshima and Nagasaki: The Physical, Medical, and Social Effects of the Atomic Bombings*, trans. Eisei Ishikawa and David L. Swain (New York: Basic Books, 1981), pp. 508-09; Ashley W. Oughterson et al., *Medical Effects of Atomic Bombs: The Report of the Joint Commission for the Investigation of the Effects of the Atomic Bomb in Japan* (Oak Ridge: United States Atomic Energy Commission, 1951); Vincent C. Jones, *Manhattan: The Army and the Atomic Bomb*, United States Army in World War II (Washington, D.C.: U.S. Army Center of Military History, 1985), pp. 543-50. See also Paul Boyer, "Physicians Confront the Apocalypse: The American Medical Profession and the Threat of Nuclear War," and Barbara Dayand and Howard Waitzkin, "The Medical Profession and Nuclear War," both in *Journal of the American Medical Association* 254 (August 1985): 633-43 and 644-51, respectively. Denit's successors as FEC surgeon were Maj. Gen. James A. Bethea (August 1946) and Maj. Gen. Edgar Erskine Hume (July 1949).

Primary responsibility for the twenty-four thousand liberated prisoners of war (POWs) fell first to Eighth Army at Yokohama, then to the 42d General Hospital in Tokyo, which began treating the survivors and processing their records. Examination of the POWs revealed the dismal effects of prolonged malnutrition and abuse. More than a third had died in captivity. Treatment had varied from camp to camp, but many prisoners—because of their long periods of incarceration (three years or more)—were “a picture of severe starvation, sunken eyes, high, prominent cheek bones, distended abdomens, [and] marked atrophy of all muscles.”¹⁶ Nutritional edema and beriberi were common. Virtually all prisoners had intestinal parasites, including *Ascaris*, *Necator* (hookworm), and *Strongyloides*. Amoebic dysentery was common.

Nearly all had “chronic productive coughs,” and in camps where statistics could be obtained, pneumonia ranked as the chief killer, causing almost half of all deaths. In the years following liberation, tuberculosis would continue to kill.

Yet, in the opinion of the doctors who examined the POWs, the key to understanding them was the fact that they were a select group, the survivors of a merciless Darwinian process that had weeded out any who lacked great toughness of mind, body, or will. Few psychoneurotic problems were observed, for men who had suffered severe depression or similar symptoms had died early. Army doctors emphasized the essential normality of the survivors, plus the powerful group bonding that had enabled them to endure. “They regard themselves as perfectly normal,” said one report, “and do not ask for nor expect pity.”¹⁷

The primary treatment for all save those who were in extremis was food. Dieticians prepared a special ration and three meals were served daily, with no limit on refills. Canteens and post exchanges stood open twenty-four hours a day for snacks. Vitamins were dispensed with a free hand. Appetites were stupendous. In the three weeks most former prisoners remained under medical care in Japan the average weight gain was 20 pounds, and 30 to 40 pounds was not uncommon. By the time they left the depots for home, there was little in the physical appearance of most to suggest to the casual observer the long ordeal they had undergone.¹⁸



BRIG. GEN. GUY B. DENIT

¹⁶USAFPAC, Report of ETMD, October 1945, pp. 106–07, RG 112, MMFB.

¹⁷Ibid., p. 108, RG 112, MMFB.

¹⁸Blanche B. Armfield, *Organization and Administration in World War II*, Medical Department, (Continued)



SANITARY INSPECTOR TAKING
WATER SAMPLES

As the POWs were processed out, the job of turning an army of invasion into an army of occupation was already under way. Typical was the experience of the medical personnel in Maj. Gen. Innis P. Swift's I Corps of the Sixth Army. After participating in many Pacific campaigns, the corps landed on 25 September 1945 at Wakayama, Honshu, and occupied the Osaka-Kobe-Kyoto area. All its units came ashore with adequate medical supplies for thirty days—a reminder of its original combat mission. Even in the beginning the drastic disproportion between the medical needs of a fighting force and an occupation force was evident. Preparations for evacuating large numbers of casualties proved to be needless. Unit dispensaries and corps collecting and clearing companies were well able to provide care for

the common run of illness and injury. Seriously ill patients, however, were carried offshore to Navy hospital ships or were flown from Osaka to hospitals in the Western Pacific. Customary medical discipline, developed during the war, was maintained and adapted to the new conditions. Medics ensured that troops took their Atabrine tablets if they were quartered in areas endemic for malaria; malaria survey and control detachments continued to operate. Preventive medicine teams used DDT freely, especially as the corps took over Japanese Army barracks infested with fleas. As quickly as possible, Americans introduced the comforts of home, nearly all of which helped to control influenza and other complaints: heated shower rooms, hot water for bathing, heated latrines. By American standards municipal water supplies proved to be contaminated, and drinking water for the posts was purified by various means, reducing the risk of enteric ills.

By early 1946 the I Corps area was heavily oversupplied with medical care, as hospitals intended to handle massive wartime casualties poured in, found shelter, and set up shop. "At the beginning of the year," reported the corps surgeon, "there were no less than eighteen Medical Department units including evacuation hospitals, portable surgical hospitals, separate, clearing and collecting companies plus the medical battalions of five divisions all trying to operate

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United States Army (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1963), p. 489. Later studies did not confirm these optimistic first assessments. See Bernard M. Cohen and Maurice Z. Cooper, *A Follow-up Study of World War II Prisoners of War*, Veterans' Administration Medical Monograph (Washington, D.C.: Government Printing Office, 1954), pp. 19–23.

hospitals of some sort in I Corps zone of responsibility, and in many cases located within two blocks of each other.”¹⁹

Because the health of the command was good, this array had little to treat. Rapid demobilization was desirable, as well as necessary, but brought with it the familiar problem of personnel turbulence. Changes in the corps’ Medical Section, reported Col. Reuel E. Hewitt at the end of 1946, were “too numerous to mention.” He himself was the fourth corps surgeon to serve during the year. Because demobilization was an individual process, governed by the point system with constantly changing criteria, neither unit coherence nor efficiency stood much of a chance. Though personnel from inactivated units were transferred to active ones, by the end of the year shortages had developed in critical specialties. The corps went from having too many medical units to having too few doctors, dentists, and technicians to care for the troops.²⁰

Throughout Japan a shrinking medical establishment faced, as its main problem, the multiplying contacts between soldiers and civilians. A military population in rapid flux eagerly sought out Japanese food and scenery—and prostitutes, who were among the least healthy of the nation’s citizens. Non-fraternization, a policy that failed in occupied Germany, was not attempted in Japan. American and Japanese health were interdependent, and the occupation authorities were obliged to improve the second in order to safeguard the first.

Underlining the danger, the epidemics of the first year took their toll among the occupiers as well as among the civilian population. The first case of small-pox in an American serviceman occurred on 29 December 1945. By the end of January 1946 sixty-one cases, including twenty-one deaths, were recorded. Clearly, some vaccinations had not taken. While the nationwide campaign to vaccinate the Japanese was under way, a vigorous revaccination drive among the military suppressed the outbreak in February. Meanwhile, a growing number of Japanese civilians found work with the occupation forces, including jobs as diverse as ward attendants in the hospitals, laboratory technicians, cooks, depot clerks, bakers, stevedores, carpenters, and charwomen. As personnel losses increased, the dependence of the Americans on such workers could only grow. Living with their families and working on American bases, these civilian employees carried disease from vanquished to victor.²¹

Nowhere was the potential health threat more evident than in the case of venereal disease (VD). Americans and Japanese brought to sex a commonality of basic impulse combined with wide divergence in cultural norms and values. Prostitution in prewar Japan was a recognized, if lowly, profession regulated by

¹⁹I Corps, Annual Report of Medical Department Activities, 1946, p. 3, file 319.1-2 (I Corps) 1946, Box 565 (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB. As of 1 January 1946, the corps had become part of the Eighth Army.

²⁰Quoted words from *ibid.*, p. 2, RG 112, MMFB. See also I Corps, Quarterly Reports of Medical Activities, 1 Jul-30 Sep 45 and 1 Oct-31 Dec 45, both p. 3, file 319.1-2 (I Corps) SWPA-1945/3 and 1945/4, Box 565, and Eighth United States Army (hereinafter cited as EUSA), Annual Report of Medical Department Activities, 1946, pt. 1, pp. 10-11, file 319.1-2 (EUSA) SWPA-1946, Box 500. Both (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB.

²¹EUSA, Annual Report of Medical Department Activities, 1946, pt. 1, pp. 1-6, 25-26, 38, 41, 43, RG 112, MMFB. The general rule in medical units was: the larger the installation, the greater the proportion as well as the number of Japanese employed.

the police. Poor parents sold girls to brothelkeepers, who in turn gave the girls their shelter and a dowry of clothing but took nine-tenths of their earnings. Debt peonage ensnared prostitutes in a web that few could ever escape. Authorities attempted to control venereal disease through a system of regular medical checkups for women in red-light districts. Yet, because the disease was associated with the prostitute class, VD cases among the respectable were concealed; physicians did not report them, and no attempt was made to trace a victim's sexual contacts. Then came the war, and the inspection system, like other forms of public health discipline, broke down. Surveys taken in September and October 1945 indicated that about 50 percent of prostitutes had syphilis and about 75 percent had gonorrhea. In Osaka a survey by the Army showed near 100-percent incidence of one or more venereal disease. In 1946 the Japanese government reported about 129,000 cases of gonorrhea and 74,000 of syphilis nationwide. Because virtually all the recorded victims were prostitutes, however, the true incidence in the general population remained unknown.²²

Young soldiers flocked to such women with the pertinacity of lemmings and in similar numbers. "Long queues of soldiers," wrote two American correspondents, "four abreast, could be seen standing, waiting their turn" outside the cribs of Tokyo and Yokosuka. In a higher-class red-light district they recorded the patter of a pimp: "'There is the 'Beautiful Flower,' Mr. Yank' . . . 'only seventeen yen, Mr. Yank, and very very new' . . . 'or 'Rose Blossom' . . . many like her, Mr. Yank, only one hundred yen. . . .'" Like some of the brothels of New Orleans and San Francisco in an earlier day, the establishments had names. One was "Brother and Sister House," another "Love House," and a mahogany sign across the doorway of one sported the simple word "Whorehouse."²³

Early efforts at control through prophylactic stations and the wide distribution of condoms were not effective; later decisions to put brothels off limits apparently enjoyed little greater success. VD rates climbed steadily to a peak of 150 cases per 1,000 troops per annum in October 1946—an epidemic rise. It should be noted, however, that conditions were worse in postwar Europe, where sex among the ruins was no less popular than in Japan and disease control proved to be even more difficult. The Occupation attacked the problem, as usual, from both the civilian and the military side. While USAFPAC cranked up a campaign of information and propaganda for GIs, SCAP ordered the Japanese government to put venereal diseases into the same category as other communicable ills. In each prefecture a standard venereal disease control ordinance provided weekly examinations of prostitutes, bar girls, and others likely to transmit infection. Penicillin treatment for victims began. The Ministry of Health and Welfare set up training courses for laboratory and VD clinic personnel. By the end of 1945 such clinics were in operation in Tokyo and Yokohama. The military adopted well-proven methods: reminding officers that VD control

²²Ibid., p. 58, RG 112, MMFB.

²³Frank Raymond Kelley and Cornelius Ryan, *Star-Spangled Mikado* (New York: McBride, 1947), pp. 150–51. See also USAFPAC, Report of ETMD, November 1945, pp. 23–24, file 350.05 (USA Forces, Pacific, Nov 45), Box 72 (USA Forces, Pacific, Aug–Dec 45), Entry 54B, RG 112, MMFB.

was a command responsibility, appointing control officers, and coordinating its campaign under the Eighth Army's chief of preventive medicine.

But results were slow in coming. The high incidence in the general population, the influx of new troops, and the reluctance of the Japanese government to violate established customs all worked against success. Efforts to suppress brothels only forced prostitutes, who knew no other means to make a livelihood, into the streets where they were even less controllable than before. Nevertheless, public awareness and military discipline both counted for something, and rates among GIs began to decline in November 1946, reaching 83 cases per 1,000 troops per annum in July 1947, after which they rose again to 94 in December. High by comparison with the United States, low by comparison with Europe, VD rates in postwar Japan reflected the usual difficulties of dealing with deeply entrenched endemic ills under postwar conditions. Traditional attitudes of shame and concealment, common to both Americans and Japanese, added to the medical burden.²⁴

Throughout the early years of the Occupation all problems were made more difficult by the influx of raw, untrained replacements. "Readjustment" began in the Eighth Army on 21 September 1945, when the first group of veteran soldiers moved into the 4th Replacement Depot near Yokohama. By November the depot was handling 25,000 men a month. On the anniversary of V-J Day in September 1946 some 272,000 officers and enlisted men already were home and about 65,000 new replacements on hand. To the possibly jaundiced eyes of medical officers the replacements seemed a poor lot, immature and untrained, plagued by psychoneurotic disabilities and boundlessly susceptible to disease. Doctors blamed not only the draft system but also the Army's inability to provide adequate training under the conditions of the time. The situation did not improve during 1946; in the winter of that year 75 to 80 percent of the replacements had had only four to eight weeks of training. Many had not even experienced the childhood diseases. Jammed into troopships to travel the Pacific by a northern route during winter, they endured voyages prolonged by bad weather from a normal ten to fourteen days to twenty-one days or more. Depots in turn were overcrowded. Influenza and scarlet fever broke out. In one ship, bound ultimately for Korea, 336 cases of scarlet fever were counted among 2,000 men. Dispersion of the replacements among the scattered occupation units helped to spread shipboard infections far and wide.²⁵

Other worries about the health of the troops proved either groundless or of no great importance in terms of the number of men affected. Ending suppressive

²⁴Above paragraphs are based on extracts from SCAP, Summation of Non-Military Activities in Japan, no. 1, September–October 1945, p. 11, no. 2, November 1945, p. 18, and no. 3, December 1945, pp. 19–20, HRB; EUSA, Annual Report of Medical Department Activities, 1946, pt. 1, pp. 30–32, RG 112, MMFB; FEC, Annual Report of Medical Department Activities, 1947, pp. 23–24, RG 112, MMFB.

²⁵Sources of this paragraph include: I Corps, Quarterly Reports of Medical Activities, 1 Jul–30 Sep 45 and 1 Oct–31 Dec 45, RG 112, MMFB; FEC, Annual Report of Medical Department Activities, 1947, pp. 1–5, RG 112, MMFB; extract from Ltr, Brig Gen James A. Bethea, Surgeon, Medical Section, FEC, to The Surgeon General, USA, 26 Aug 47, sub: Outbreak of Common Respiratory Diseases in Japan and Korea During the Winter of 1946–1947, HSF (Bethea–1947), HRB.

malaria therapy in nonendemic areas resulted in flareups among veterans infected during the Pacific war. An outbreak of poliomyelitis in the summer of 1947 brought the Virus and Rickettsial Commission of the Army Epidemiological Board to Japan. Fortunately, the number of cases—187—was small. For a time in 1947 rheumatic fever similarly caused concern, the disease, with its dangers to the heart, following as a consequence of the scarlet fever outbreak. Incidence, however, never rose above 0.7 cases per 1,000 troops per annum. Cholera and typhus apparently took no toll among servicemen. The commoner enteric diseases were another matter. Outbreaks of dysentery occurred among the troops, and amebiasis was described in 1947 as “prevalent throughout the [Far East] Command,” while roundworm infestation was “not unusual.” Japanese food-handlers, civilian food stalls, and the near impossibility of controlling the spread of such complaints in a land that fertilized with night soil were the probable culprits. However, the tropical posts of the command in the Philippines and Guam had a higher incidence than either Japan or Korea, and within these nations American disease rates were enviable by local standards.²⁶

As the difficult years immediately following the war gave way to more orderly and normal conditions, both in the Army and in Japan, the medical picture brightened accordingly. If medics were few, so were the troops; by November 1946, for example, the actual strength of the Eighth Army had dropped to less than 60,000 men as against its authorized strength of more than 100,000. Recruits also received more extensive screening and training at home. But above all, the health of the troops improved with that of the Japanese civilian population. The Medical Department, on the whole, could look back with satisfaction on the combination of good management, discipline, and luck that had brought the forces occupying Japan through the early years.

The Occupation of Korea

In Japan, sound and compassionate policy was preparing what in time of crisis would prove to be a secure base, if not a second homeland, for American forces. Across the Korea Strait, in a little-noticed sideshow, geography, great power rivalry, and confused American purposes helped to prepare a historic tragedy.

When Americans of the 7th Infantry Division entered Korea at the port of Inchon on 8 September 1945, they encountered a people who were, even for that turbulent time, troubled and uncertain of their future. Korea was a paradox, a land of independent and long-established culture doomed by geography to foreign invasion and to strong, contradictory foreign influences. An incomplete land-bridge between China and Japan, Korea from early in the Christian era was exposed to Chinese cultural influence and occasional invasions from both of its neighbors. The nation declined during the eighteenth and most of the nineteenth century in self-imposed isolation from the world. Soon afterward the

²⁶FEC, Annual Report of Medical Department Activities, 1947, secs. 1, 2, and 6, RG 112, MMFB.

rivalries of China, Japan, and Russia engulfed it. The Japanese defeated each of the others in turn, deposed the Korean emperor, established a colonial regime under a governor-general, and annexed Korea in 1910.

In 1945 the Korean people emerged from the colonial state with their nationalism intact, indeed probably intensified. They had little experience of government and felt a deep hatred of the Japanese, whose policies had left them a country in which modern and medieval mingled oddly and jarringly. Complicating a difficult rebirth was a new foreign intrusion. Both Americans and Russians, for their own ends, proceeded to bring about the one thing that all Koreans viewed as intolerable—the division of the country into two zones with vastly different governments. The zones then evolved into two nations. In the North, a coherent, repressive, and well-armed Communist state rapidly took form, drawing some of its strength from native revolutionary impulses. In the South, party strife, peasant uprisings, and conflict among potential leaders yielded only gradually and imperfectly to an emerging strongman, former exile Dr. Syngman Rhee, and the American military that backed him.

By comparison with Japan, to say nothing of the undestroyed parts of the Western world, Korea was an undeveloped country. In one way the nation was more fortunate than its former rulers, for, spared bombing, Korea was free of extensive physical destruction. In most ways, however, its condition was worse. The political division of the country separated the industrial and agricultural north from the less industrial rice-growing south, building into the latter's economy a fundamental, and for the time at least, incurable flaw. In place of an established national government through which to work, the Americans who occupied southern Korea found only the police and the bureaucracy of the Japanese colonial regime. Because the higher-ranking officials, including those who had run the public health system, were Japanese, they were anathema to the Koreans. Korean doctors by and large were ill-trained, while practitioners of folk medicine treated patients with herbs and acupuncture. For the Americans, the task before them in Korea was at least as great as that in Japan, but the means were less and the time—the Occupation would end in mid-1949—was shorter.²⁷

American Policy and Korean Ills

Until August 1948, when the Republic of Korea was proclaimed, General MacArthur in his capacity as supreme commander bore responsibility for the occupation and government of Korea south of the 38th Parallel. The immediate tasks of establishing order fell upon the XXIV Corps, whose troops, after fighting in the Philippines and on Okinawa, were diverted from the planned invasion of Honshu to occupation duty in Korea instead. Lt. Gen. John R. Hodge commanded. For a time the corps carried on military government as a staff function,

²⁷Extract from Department of Public Health and Welfare, United States Army Military Government in Korea (hereinafter cited as USAMGIK), Historical Summation, September 1945–May (Continued)



KOREAN CIVILIANS WELCOMING U.S. OCCUPATION TROOPS

but in January 1946 a new headquarters, the United States Army Military Government in Korea, was set up.

Public health functions, however, predated the military government. On 24 September 1945 a Bureau of Public Health was established to replace a police-run bureau that had existed under the Japanese. The following month the name—reflecting a wider range of services—was changed to the Department of Public Health and Welfare. By the end of the year the department contained about fifty American officers, drawn from the Army and the Navy, and thirty enlisted men. Training programs opened for Koreans, and by the end of the year twenty-two students had completed a six-week course in public health at Seoul University. At the request of the military authorities the Rockefeller Foundation granted ten fellowships to Korean physicians to study public health. As a trickle of competent Koreans began to enter the program, the Americans shifted to an advisory role. U.S. civilians from the War Department, too, arrived during 1946 to help man the system. At SCAP Colonel Sams selected Col. John K.

(Continued)

1947, p. 3, HSF (USAMGIK Summation, 1945–47), HRB; James P. Pappas, “Civil Assistance to the Republic of Korea: Public Health, 1950 Through 1954,” Professional Papers, Box 34, Group 3, Medical Historical Unit Collection, Archives, U.S. Army Military History Institute, Carlisle, Penn. A recent and detailed revisionist history of Korea in the postwar years is Bruce Cumings, *The Origins of the Korean War: Liberation and the Emergence of Separate Regimes, 1945–1947* (Princeton: Princeton University Press, 1981).

Cullen, a Medical Corps officer, to be director of public health and welfare; later Col. William R. Willard, a Public Health Service officer then serving with the Army, succeeded Cullen.

Meanwhile, the purely military side of the Occupation also took form. Under Col. Laurence A. Potter, the Surgeon's Section, XXIV Corps, opened for business at Seoul on 11 September 1945, and in the same month the Army Service Command 24 (ASCOM 24) established itself nearby at a former Japanese arsenal 8 miles from the port city of Inchon. Soon ASCOM 24 was able to provide hospitalization and dispensary service to all the troops in Korea from its base, which became known as Ascom City.²⁸

Their first hard look at Korean conditions was not encouraging, either to commanders or surgeons. Though South Korea was a land of temperate climate—with pleasant springs and falls, oppressive summers, and severe winters—its disease environment was all too typical of undeveloped regions. The landscape was varied, mountainous in the east where the Taebaek Range formed the spine of the peninsula, flatter in the rice-growing west; the coast from Pusan to Seoul was broken, diversified with natural harbors, coves, islands, and headlands. The lives of most of its people were bound up with their villages; in the uneven landscape, each mountain, valley, and tiny plain with its fields of rice, millet or barley had a unique appearance and character. Far removed from the farmer's life—by time more than by space—was the urban world of Seoul, where some American troops coming straight from combat duty found themselves quartered in spacious, modern hotels with steam heat and flush toilets.

It was, however, the medieval not the modern Korea that shaped the country's disease environment. Smallpox, cholera, and typhus were endemic, as were filariasis and Japanese encephalitis. Tuberculosis was a common cause of death. Water supplies were usually polluted. Mosquitoes and flies abounded. Throughout Korea, shallow privies made easier the work of farmers and night soil contractors, for here, as in Japan, human excrement was an essential fertilizer. Though spared ground fighting or heavy bombing, Korea showed everywhere the deterioration that resulted from lack of maintenance and repair during wartime. Roads were rough, especially for ambulances; buildings, including hospitals, were dirty and decaying; laboratories were empty of supplies, their equipment worn out or broken; and communications everywhere were difficult.

Under these conditions the inevitable mixing of troops and civilians posed alarming possibilities. The movement of refugees—some 2.8 million either entered or left the country by the end of 1946, plus thousands whose movements were unrecorded—threatened to make all medical problems worse. As in Japan,

²⁸*Civil Affairs/Military Government Public Health Activities*, p. 690; USAFFE and EUSAR, "Logistics in the Korean Operations," vol. 1, pp. 1–2, RG 319, MMHB; XXIV Corps, Annual Report of Medical Department Activities, 1946, p. 1, file 319.1–2 (XXIV Corps) 1946, Box 567 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; Army Service Command 24 (hereinafter cited as ASCOM 24), Quarterly Report of Medical Activities, 1 Oct–31 Dec 45, pp. 1–2, file 319.1–2 (ASCOM 24) SWPA, Box 555 (WW II Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; extract from SCAP, Summation of Non-Military Activities in Japan and Korea, no. 3, December 1945, p. 202, HSF (SCAP Summation, 1945–46), HRB; extract from Ltr, Col John K. Cullen, Director, Department of Public Health and Welfare, to Col Crawford F. Sams, Chief, Public Health and Welfare Section, SCAP, 4 Apr 46, HSF (Cullen–1946), HRB.

American commanders and their surgeons organized to protect the troops while energetically seeking to improve the health of the Korean people.²⁹

Outbreaks of disease soon confirmed early forebodings. Smallpox began an epidemic rise during the winter of 1945–46. Like the Japanese epidemic, it occurred despite a prewar program of vaccination, apparently because poor technique had left many people unprotected. The military government ordered a nationwide program aimed at vaccinating properly every person south of the 38th Parallel. Three million units of vaccine were made available from Army stocks, and the disease, after reaching a peak in April 1946, fell off rapidly. Though the epidemic was contained, a nationwide effort designed to prevent recurrence got under way in October, using 18 million doses of vaccine produced in the civilian National Veterinary Laboratory at Pusan, which the Koreans, with Army assistance, had gotten back into operation. All refugees crossing the parallel and all Japanese repatriates were inoculated in an effort to prevent the disease from spreading. Efforts among the local population aimed first at schoolchildren, government and railroad workers, and medical personnel. As a result, in the second winter of the Occupation only 113 cases were reported, most resulting from infection spread by a single person who had visited North Korea shortly before taking sick.³⁰

Typhus too appeared in 1945, its incidence rising into 1946 and reaching a peak in the same month as the smallpox epidemic. In all, there were about six thousand cases during 1946 and some twelve hundred more during the early months of 1947. The authorities resorted to local spraying and inoculation, finding in the isolation of much of the Korean people an obstacle both to the spread of the disease and to treatment when it did occur. During the spring and summer of 1946 cholera also appeared. Introduced in May by repatriates from Shanghai, the disease spread along the rail lines west and north from the port of Pusan. The military government immediately clamped drastic control measures on the infected region, which by mid-June seemed to be succeeding. Then, in the last week of June, a deluge of heavy rain washed out roads and bridges, flooded towns, and disrupted communications. Water from flooded cesspools and latrines seeped into the shallow wells on which rural Korea depended. Transport of medical supplies and personnel came almost to a standstill. Great areas were grossly contaminated with the *Vibrio cholerae*, the waterborne organism that causes the disease.

The public health and welfare system now got a thorough workout. Each of the nine provincial health departments set up a cholera control headquarters

²⁹William R. Willard, "Some Problems in Public Health Administration in the U.S. Army Military Government in Korea," *The Yale Journal of Biology and Medicine* 19 (March 1947): 661–70; Takashi Senoo and R. D. Lincicome, "Incidence and Distribution of Malayan Filariasis in Southern Korea," Professional Papers, Box 65, Group 2, Medical Historical Unit Collection, Archives, U.S. Army Military History Institute, Carlisle, Penn.; XXIV Corps, Annual Report of Medical Department Activities, 1947, pp. 2, 11–12, 13–14, 15, file 319.1–2 (XXIV Corps) 1947, Box 567 (WW II Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; Surgeon's Circular Letter 5, no. 12, Medical Section, FEC, 1 Dec 50, file 300.5 (Circular Letters) FEC, HRB.

³⁰Extract from USAMGIK, Historical Summation, September 1945–May 1947, p. 4, HRB; extract from Commander in Chief, USAFPAC, Summation of United States Army Military Government Activities in Korea, no. 7, April 1946, p. 32, HSF (USAFPAC Summation–1946), HRB.



SMALLPOX WARD IN THE SEOUL COMMUNICABLE DISEASE HOSPITAL

and sent out case finding teams, for the problem was not only to treat but also to find the sick. Provincial and community health departments manned by Americans and Koreans swung into action. Mobile teams set up quarantine barriers and carried out mass inoculations. Houses, neighborhoods, and in some cases entire communities were sprayed with DDT in the belief that transmission by flies might occur. Korean laboratories turned out cholera vaccine. Supply points were set up by the military and the provincial authorities to provide safe water. The military government pressed radio, newspapers, posters, community organizations, and itinerant speakers into a massive nationwide information campaign. Yet the nature of Korea, the inability of many of its doctors to report accurately on disease, the lack of adequate laboratories for analysis, and all the problems of transport and supply worked against the effort. Incidence declined month by month after the July resurgence, but the disease did not disappear until late November. About sixteen thousand cases had occurred, with the number of fatalities totaling between eight thousand and ten thousand.

The black death also appeared to threaten. A natural reservoir of the disease which had devastated the civilized world for three centuries existed among the wild rodents of Manchuria. During the period of disorder that stretched from the Opium Wars of the nineteenth century to the Japanese invasion and Communist-Kuomintang civil war of the twentieth, bubonic plague had broken out frequently in China. On 26 March 1946 a Korean nurse who vaccinated refugees

crossing the 38th Parallel from North Korea and Manchuria died of a disease that was diagnosed as the plague. Less than three weeks later a five-year-old girl also perished. Though laboratory identification was not completely convincing, the military government sensibly treated the diagnosis as confirmed. Military personnel throughout Korea received plague shots, as did civilians in Chunchon, northeast of Seoul, where the two cases had been reported. Refugees were dusted, immunized, and held at the border for a ten-day quarantine. Examination of rats and mice trapped in the area yielded curious and interesting results. Plague is a disease of rodents transmitted to humans by fleas. The animals tested had few fleas, possibly because of the DDT, but there were not many of the rodents themselves. Seriously infested with liver tapeworms, the local rats and mice were few in number and so were less available to serve as carriers of plague.³¹

The Army's veterinary officers also had epidemics to contend with. During 1946 rinderpest, a viral disease of cattle that causes fever and diphtheria-like symptoms, broke out in the Russian zone. Veterinarians obtained laboratory animals, began to produce vaccine, and inoculated cattle throughout a zone 15 miles wide south of the 38th Parallel. Maintenance of the immune zone effectively barred the further advance of the disease. A similar epidemic outbreak in domestic fowl was brought under control by immunizing poultry flocks.³²

Little could be done against the endemic diseases. Studies had shown Koreans to be all but universally infected with parasitic worms and protozoa, including *Entamoeba histolytica*, the cause of amoebic dysentery. So common was such infestation that Koreans appeared to have adapted to it; cases of clinical symptoms resulting from the infestations were rather rare, even among people carrying *Entamoeba*, though tests showed these protozoa to be "pathogenic for cats." A threatening problem was the commonness of malaria. Caused by *Plasmodia*, parasitic protozoa that attack the liver and red blood cells, the disease was considerably more common than in Japan. Incidence appeared to be rising in the early years of the Occupation. An indeterminate number of cases occurred among civilians, guesses ranging from ten thousand to one hundred thousand a year. Surveys among schoolchildren showed that from 1.3 to 8 percent were infected, varying from school to school. About sixteen hundred Japanese soldiers were known to have come down with the disease in early 1945. Though widespread use of DDT reduced the number of vectors, no victory could be claimed. Most Korean houses were unscreened, antimalarial drugs were in short supply, the large reservoir of infected people remained, and the rural, geographically fragmented nature of the country ensured that suppression of the disease would be as difficult as possible.³³

³¹Above paragraphs are based on XXIV Corps, Annual Report of Medical Department Activities, 1946, pp. 22-31; USAFPAC, Report of ETMD, November 1945, pp. 13-18. Both in RG 112, MMFB.

³²Extract from Commander in Chief, USAFPAC, Summation of United States Army Military Government Activities in Korea, no. 6, March 1946, p. 20, HSF (USAFPAC Summation-1946), HRB.

³³XXIV Corps, Annual Report of Medical Department Activities, 1946, p. 27, RG 112, MMFB.



AMERICAN NURSE INSTRUCTING KOREAN NURSES *on how to make a hospital bed properly*

Even greater problems beset the effort to control tuberculosis. The Army established a modern sanatorium in a remodeled Japanese hospital, and the Department of Public Health and Welfare established a Korean Anti-Tuberculosis Association. The organization was active for a short time, but, due to a lack of supplies, it later had to discontinue its work. X-ray equipment was not available. Indications were that the disease, as in Japan, was a serious and general health problem. Yet after two years of occupation there was no functioning tuberculosis section in the Department of Public Health and Welfare.

By and large, the Army conducted a holding operation. The Korean occupation was hasty and ill-prepared, with few Americans realizing the “magnitude, complexity, or technical nature of military government until too late.”³⁴ Plunged into an exotic disease environment with inadequate resources, Army doctors responded under the direct pressure of epidemic outbreaks and in the face of almost heartbreaking difficulties.

Army supplies and war surplus were used generously to aid the Korean people. In 1946 some 360 prepacked medical units arrived, each containing enough supplies to treat ten thousand people for thirty days. Included in the units were 18,000 bottles of sulfathiazole and sulfadiazine which were distribut-

³⁴Willard, “Some Problems in Public Health Administration,” p. 670.

ed to the provinces. In January 1947 eighty-seven carloads of surplus medical supplies arrived in Korea. Fifty-three carloads of Army rations went to public hospitals and clinics that same year. No less important—indeed, far more important in the long run—were the Army's contributions of skill. The aim was not merely to help Koreans, but to help them to help themselves. Under American guidance their laboratories made advances in a variety of sophisticated techniques, producing biologics, and making studies in nutrition, toxicology, biochemistry, sanitation, and drug analysis. Efforts to train, upgrade, and improve the health care professions included work by American nurses to lift both the standards and the status of Korean women in what had been, with few exceptions, an ill-trained and lowly occupation. A National Board of Licensure and Registration was set up to improve the standards of physicians, and another for dentists.

Yet the fact remained that in Korea fewer Americans than in Japan, under a subordinate headquarters, had to do a job of great complexity in less time than their colleagues across the Korea Strait. Though the population was less than half that of Japan, its primitive lifestyle and long history of exclusion and abuse made it difficult to enlighten quickly. Recurring political upheavals and revolutionary violence placed further obstacles in the way of progress. In mid-1947 the military governor reported that "it is doubtful if any project to educate the public regarding public health has been successful except to a very limited degree." The permanent upgrading of Korean health care could only be a long process, and Korea did not, in this respect or any other, stand high on the list of American national priorities.³⁵

Americans in Korea

Typical of the experiences of the American troops who occupied Korea were those of the 7th Infantry Division. The tide of battle during World War II had carried the Hourglass Division from the Golden Gate to the Aleutian fighting; thence, via Hawaii to battle again at Eniwetok, Kwajalein, Leyte, and Okinawa. Poised for the invasion of Japan, the division was instead diverted to Korea, where its advance party landed on 8 September 1945. Initially, its mission, like that of other elements of the XXIV Corps, was simply to disarm and repatriate the Japanese occupiers. Instead, for almost four years it performed occupation duties in a poor, remote, and turbulent nation. During that time the 38th Parallel turned from a formal demarcation line to an armed border, and relations with the Russians in the North passed from correct to frosty. In consequence, the duties of the regiments rotating in outpost duty along the parallel

³⁵Quoted words from extract of USAMGIK, Historical Summation, September 1945–May 1947, p. 7, HRB. See also *ibid.*, pp. 10–11, 18, HRB; United States Army Military Government in Korea (hereinafter cited as USAMGIK), Annual Report of Medical Department Activities, 1946, pp. 1–3, file 319.1–2 (USAMGIK) SWPA–1946, Box 498 (WW II Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; extract from SCAP, Summation of Non-Military Activities in Japan and Korea, no. 4, January 1946, p. 293, HSF (SCAP Summation, 1945–46), HRB; "Nursing Affairs in Military Government," *Bulletin of the U.S. Army Medical Department* 5 (June 1946): 643–44.

shifted gradually from peaceful bivouac to a condition resembling war. Overlooking the crowded valleys and barren, largely treeless hills through which one of the world's most arbitrary boundaries ran for 150 miles from the Yellow Sea to the Sea of Japan, the men of the 7th came to lead a rigorous, vigilant life that was not without danger. Snipers shot at patrols, and lone soldiers were kidnapped on occasion when the North Koreans wished to provoke a border incident.

Health problems during the first winter were largely confined to widespread respiratory complaints as troops who had been fighting in the tropics encountered the Korean winter. By mid-December rivers were frozen to a depth of 1 to 2 feet, and snowfalls of an inch or more occurred once or twice a week. The soldiers shivered in makeshift quarters with inadequate heat. An engineer construction program and the influx of supplies and materiel gradually met the problem of housing, though medical officers admitted that they, and no doubt the men they cared for, saw the arrival of spring with relief. During the year that followed, the pressures of the new environment became less important and those of contacts with the civilian population relatively more so.

Meanwhile, the medical system experienced upheavals of its own. The early organization under ASCOM 24 gave way in early 1946 to a new arrangement, as the service command underwent reorganization into Korea Base Command (KBC). Simultaneously, much of the responsibility for medical and hospital units passed to XXIV Corps headquarters, as the 80th Medical Group shifted from ASCOM to become the corps' medical operating agency. The early excess of medical units intended to support an invasion gave way, as it had in Japan, before the pressures of demobilization. By early 1947 the vast majority of troops in Korea received dispensary care from their unit medical personnel, while the medical group provided higher-echelon care through five station hospitals, one general hospital, and a dental prosthetic detachment. Transport was the responsibility of a motor ambulance company. Medical supplies were received, stored, and issued by the 9th Medical Depot Company attached to the Korea Base Command and located in Ascom City. The XXIV Corps surgeon coordinated and supervised all medical activities for American personnel stationed in Korea, and advised the commander, General Hodge, on all medical questions, including civilian health as it affected the command.

Within this simple structure, turbulence rather than clarity was the rule. Personnel instability was no less troublesome in Korea than it was elsewhere. Medical units shared fully in the problems caused by shifting criteria for discharge, the difficulty of retaining experienced people, and the entry of untrained replacements. Retraining was essential if new men whose skills were limited to those acquired in infantry basic were to replace veteran technicians. Yet those who might have trained them also were departing in wholesale batches. Among officer personnel, too, make-do became the rule, as nurses took over for lost administrative officers, young doctors filled in for specialists, and line officers were temporarily called in to fill medical command slots. Though by March 1947 efforts at manpower conservation had reduced the XXIV Corps' bed strength by one thousand, as well as Korea's total medical personnel needs by 35 percent, the turnover continued distressingly high. Virtually a complete change

of nurses occurred in June 1946, due not only to demobilization but also to an FEC rotation policy which was designed to make service in the command less unattractive to women. Both officer and enlisted replacements generally failed to keep pace with losses. As a result, Koreans by the hundreds were brought into the hospitals, depots, and motor pools; by the end of 1947, about twelve hundred were employed by the medical units.³⁶

As in Japan, this influx helped to underline what military authorities already had realized—that permanent separation of soldier and civilian was impossible. The influence of the civilian disease environment was forcefully demonstrated early in the Occupation when forty-four Americans caught smallpox during the epidemic of 1945–46 and eighteen died, compelling the emergency revaccination of all military personnel. On the other hand, Army health care was pervasive, discipline strong, and life within the cantonments followed American norms. Thus in the first months typhoid was absent as far as the troops were concerned; only two cases of typhus occurred, both mild. Though malaria broke out with the discontinuance of suppressive therapy, doctors comforted themselves with the belief, which may have been correct, that these cases were acquired during service in the Pacific war.³⁷

Off base, the problems that confronted the corps surgeon were less easily met. Food and drink were evident causes of concern under Korean conditions. Colonel Potter ordered strict inspections of restaurants and put off limits any which did not meet minimum standards. As a result, during the last months of 1945 there were in all Korea only sixty establishments open to the troops. Bars were put off limits after nineteen cases of wood alcohol poisoning brought local liquor brands to the attention of Army inspectors. "About twenty-five (25) brands were examined," the surgeon reported, "and no safe liquor was found [;] some contained as high as fifty percent (50%) methyl alcohol. . . ."³⁸ Bottled beer was, for the time being, the drink of law-abiding GIs.

Rigorous inspection of all civilian facilities combined with immunization of the troops against the prevalent diseases became the watchword of the command. Municipal water systems were checked out, and the water, especially after the cholera outbreak, heavily chlorinated. Throughout the Army, veterinary officers, their traditional function lost to mechanization, already had turned to food inspection as their primary duty. Their work became exceptionally important in Korea. Attached to ASCOM 24, and later to the Korea Base Command, three veterinary food inspection detachments operated at Seoul, Inchon, and Pusan, and inspected all the food that was received, stored, and issued at the quartermaster depots in those cities. They also aided Koreans in

³⁶Above paragraphs are based on ASCOM 24, Quarterly Report of Medical Activities, 1 Jan–31 Mar 46, pp. 1–8, file 319.1–2 (ASCOM 24) SWPA, Box 555 (WW II Admin Recs, 1940–49), Entry 54A; USAFPAC, Report of ETMD, May 1946, file 350.05 (USA Forces, Pacific, May 46), Box 73 (USA Forces, Pacific, Jan–Oct 46), Entry 54B; XXIV Corps, Annual Report of Medical Department Activities, 1947, pp. 1–6, 17–19, 24–26. All in RG 112, MMFB.

³⁷ASCOM 24, Quarterly Report of Medical Activities, 1 Oct–31 Dec 45, pp. 11–16, RG 112, MMFB.

³⁸XXIV Corps, Quarterly Report of Medical Activities, 1 Oct–31 Dec 45, p. 4, file 319.1–2 (XXIV Corps) SWPA–1945/4, Box 567 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB.

the care of their animals, for the departure of the Japanese left only thirty graduate veterinarians south of the 38th Parallel. The veterinary officers appear to have been very busy men.³⁹

Sex, like food and drink, brought soldiers and civilians together. During 1946 the incidence of venereal disease rose steadily, reaching levels comparable to those for Japan, and then went even higher. Military authorities put off limits the brothels that had flourished under the Japanese. Some houses were apparently broken up, dispersing the prostitutes and making control more difficult. Most prostitutes had one or more forms of venereal disease; syphilis ran about 75 percent, by one study, and gonorrhea about 85 percent. Despite efforts that included indoctrination, sermons, establishment of prophylactic stations, and issuing condoms, the resulting disease rate among American troops rose from 22 to 102 cases per 1,000 during 1946, and by mid-1948 stood at 185. Army doctors recognized that the dreary conditions of Korea, the lack of recreation, and the fact that respectable women were allowed little contact with soldiers, contributed to the situation. The KBC surgeon, toward the end of the Occupation, declared that the anti-VD program had "failed because [the authorities] offered nothing better." This may have been overly harsh; 1946 levels approximated those of Japan, while the higher 1948 level reflected the loss of military control over prostitutes following the establishment of the new Korean government. In any case, under Korean conditions little could have been offered the young soldier, in the absence of military brothels, which he would have considered better.⁴⁰

Other endemic diseases showed similar patterns. While there were no epidemics among the American troops in 1946, save for the smallpox outbreak that overlapped from the previous year, indications were that they might be acquiring the more tenacious of the local diseases. Intestinal parasites showed up in the soldiers, the number in a given individual directly proportional to the time spent in Korea. Amoebic dysentery occurred sporadically. Infectious hepatitis, a disease of which little was known, first appeared during 1945 and afflicted about 250 men in the following year. Malaria rates soared; the illness spread by a native vector breeding in the rice paddies and irrigation ditches. Yet local conditions were not the only cause of illness. Respiratory diseases followed a seasonal pattern not confined to Korea, and in 1947 a serious epidemic of scarlet fever was simply the local version of the outbreak then occurring in Japan.⁴¹

Yet, though the problems of Korea were many, American troops were at no time seriously incapacitated by disease. Psychiatric problems were common among new arrivals, whose state of mind was influenced in part by Korean

³⁹Ibid., pp. 43–44, RG 112, MMFB.

⁴⁰Quoted words from Korea Base Command, Annual Report of Medical Department Activities, 1948, pp. 6–7, file 319.1–2 (Korea Base Command) SWPA–1948, Box 557 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB. See also extract from USAMGIK, Historical Summation, September 1945–May 1947, p. 7, HRB; XXIV Corps, Annual Report of Medical Department Activities, 1946, RG 112, MMFB; FEC, Annual Report of Medical Department Activities, 1948, p. 16, file 319.1–2 (FEC) 1948, Box 498 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB.

⁴¹XXIV Corps, Annual Reports of Medical Department Activities, 1946, pp. 18–22, and 1947, pp. 10–11, 18–19, RG 112, MMFB.

conditions and, in no small measure, by their own immaturity. The first winter found even veterans suffering from such symptoms, at a time when life in Korea for everyone was singularly bleak. The improvement in living conditions, and perhaps a more rigorous training schedule, later reduced the problem to levels that were not considered serious. Even during the epidemic year of 1946 the health of the troops was surprisingly good, and conditions improved as the Occupation matured. Though Americans stationed there suffered from ills they would not have encountered at home, Korea as a duty station was not a pesthouse.

The last full year of the Occupation, 1948, found the country in turmoil over the first elections in Korea's history. Medical conditions, however, showed many similarities to those of the previous years. The employment of Korean civilians increased. On the one hand, this meant improved care for some Army hospital patients as graduate Korean nurses entered the hospitals to fill vacant positions and as regular training programs for Korean orderlies brought more, and increasingly skilled, assistants into the wards. But the diseases of the population at large entered the kitchens, houses, mess halls, offices and hospitals of the Army. The system of regular physical examinations for employees and a battery of tests—rectal smears, stool samples, fluoroscopy, blood tests, and so forth—apparently had limited utility. Thousands of people were, in effect, traveling back and forth from a medieval to a twentieth-century environment twice a day. Food-handlers may have been the source of the hepatitis that continued to alarm medical personnel. If so, Western science, which could not yet identify the virus that caused it, had no way to detect the fact. Diarrheal diseases as well continued to flare from time to time.⁴²

By this time, the brief American occupation was drawing to an end. One by one, beginning with the 89th Station Hospital, units were reduced by transfers to the status of paper organizations, or simply were shipped home. On 15 August 1948, in impressive ceremonies, General MacArthur hailed the birth of the Republic of Korea and the presidency of Syngman Rhee. In June 1949 the last troops sailed for Hawaii. On 1 July the United States Military Advisory Group to the Republic of Korea (KMAG) came into existence. A part of the American Mission in Korea headed by Ambassador John J. Muccio, KMAG remained to counsel and assist the fledgling state on military matters. A medical section of one doctor, a dentist, six enlisted men, and a nurse stayed to care for KMAG personnel and their dependents, most living in Seoul at Camp Sobinggo. Because the ambassador as head of the mission did not report to General MacArthur, all FEC responsibilities for events in Korea ceased, except for logistical support that ended at the waterline.⁴³

⁴²USAMGIK, Annual Report of Medical Department Activities, 1947, p. 2, file 319.1-2 (USAMGIK) SWPA-1947, Box 498; United States Army Forces in Korea, Annual Report of Medical Department Activities, 1948, file 319.1-2 (USAFIK) 1948 in XXIV Corps folder, Box 567. Both (WWII Admin Recs, 1940-49), Entry 54A, RG 112, MMFB.

⁴³Robert K. Sawyer, *Military Advisors in Korea: KMAG in Peace and War*, Army Historical Series, ed. Walter G. Hermes (Washington, D.C.: Office of the Chief of Military History, Department of the Army, 1962), p.53; 8086th Army Unit, Military History Detachment, "Evacuation of Refugees and Civilians from Seoul, June 1950 and December 1950 to January 1951," Ms no. 8-5.1A AT, RG 319, MMHB.

The results of the Occupation seemed at the time to be of little but local importance. A South Korean state had emerged, its future clouded by a rival government, but its fate by no means predetermined. American forces by and large had endured well an assignment that few cherished. The medics had a flawed but respectable record, for they had struggled against great odds to leave the health of the troops generally good and that of the Korean people improved. At no time had they possessed the means of bringing about revolutionary changes in health care. But they were instrumental in spearheading the programs that contained the epidemics and raised the professional standards of Korean doctors and nurses.

To thoughtful Americans the future of the Koreans seemed problematic. Maj. Gen. William F. Dean had served as military governor from 1 October 1947 to the proclamation of independence, and thereafter as commander of the 7th Infantry Division. Leaving his command to join the staff of the Eighth Army—he shortly would secure a new post as commander of the 24th Infantry Division occupying southern Japan—he felt that he would never return to Korea, and he had no desire to do so. The “short Korean chapter in my life,” he later would write, “was definitely over. . . . I certainly was not lonesome for the variable climate of that appendix of northeastern Asia.”⁴⁴ In all probability, most of those who served in Korea would have echoed these sentiments.

Japan Under the Later Occupation

Meanwhile, many Americans were finding life in occupied Japan more than satisfactory. “Jim and Julie both look fine,” wrote a medical officer’s wife from the Far East to the wife of an OSG officer, about mutual friends. “She is liking life in Tokyo and he is having a most interesting time as a public health officer. He travels around quite a bit soliciting and apparently getting cooperation from the local officials in various towns, and meanwhile picking up some amazing lore on oriental medicine. . . .” Julie “bought Randy, who was three last week, a darling two-piece linen suit for which she had paid *fifty-two cents*.” Like their comrades, Medical Department personnel “obtained, for reasonable prices, rugs, silverware, china, and cloisonne, damascene, and lacquer articles produced in Japan or China.”⁴⁵

After July 1949 the Medical Section, Far East Command, had a new chief surgeon, Maj. Gen. Edgar Erskine Hume. A controversial figure, Hume was a doctor of good education and wide experience. He was also a cultivated man with a long bibliography of clinical, scholarly, and military writings, and an officer of distinguished attainments in both World Wars, most recently in the field of military government. His communications to the surgeon general revealed a broad knowledge of the command as well as a talent for suave flattery of his superior.

⁴⁴William F. Dean, *General Dean's Story* (New York: Viking Press, 1954), pp. 12–13.

⁴⁵First quotation as related in Paul I. Robinson, “About the Medical Department,” *Bulletin of the U.S. Army Medical Department* 9 (December 1949): 981. Second quotation from *ibid.*, “About the Army Medical Department,” *United States Armed Forces Medical Journal* 1 (May 1950): 603.

Yet Hume's service in the Far East was marked by an obsessive pursuit of not only objets d'art for his personal collection but also awards and medals, whether significant or not. Voicing an opinion that was widespread in the command, Col. Chauncey E. Dovell, the Eighth Army surgeon, said flatly, "General Hume was primarily interested in souvenir hunting. He seemed to collect the damndest stuff." Hume's love of medals inspired even more scorn from Dovell, who remembered

going to Tokyo to see him decorated by the Nationalist Chinese. They gave him the Order of the Pink Elephant, or some similarly sounding decoration. It hung down in front of him like a Hottentot's apron. I almost fell out of my chair laughing when I saw it for the first time. And do you know, he wrote the award himself. I could tell by the way the citation was phrased that he had actually written it himself.

"General Hume's avidity for decorations," Dovell concluded, "took some extreme forms."⁴⁶

Whether Hume provided more than formal guidance to his capable staff is unclear. Prominent among the staff officers were Hume's deputy, Col. Richard H. Eckhardt, a physician, and his executive officer, Col. Robert E. Selwyn of the Medical Service Corps, both of whom would serve throughout 1950. The chiefs of the Medical Section's major divisions—administrative, plans and operations, personnel, and supply and fiscal—were able administrators. Col. Harold G. Ott had responsibility for the dental health of the command. The consultants division was important not only in maintaining professional quality but also in placing specialists in the most effective slots. Col. Oral B. Bolibaugh, the orthopedic consultant from early September 1949, headed the division.⁴⁷

Guided by these men, and with an able Eighth Army surgeon in Colonel Dovell, the occupation forces reaped the benefits of the earlier years. Public health in Japan now approximated that of the United States in many respects. Mild epidemic outbreaks—of polio, encephalitis, and childhood diseases—did occur. Troops on bivouac near Mount Fuji in the fall of 1948 suffered twenty-five confirmed cases of scrub typhus, a mite-borne disease known in Japan as tsutsugamushi fever, but no deaths resulted. The most common illnesses, possibly related to irritation caused by Japanese heating arrangements, were respiratory infections. Psychoneurotic problems tended to increase, despite or perhaps because of the lack of great external stress. The typical patient, if in uniform, was a newly arrived recruit, eighteen or nineteen years old, and away from home for the first time. Other patients were Department of the Army civilians, a number of whom were chronic alcoholics.⁴⁸

⁴⁶Interview, Samuel Milner with Col Chauncey E. Dovell, MC (hereinafter cited as Dovell Interview), 21 Sep 66, p. 17, Personal Interviews file (Dovell), HRB.

⁴⁷FEC, Annual Report of Medical Service Activities, 1950, pp. 1–21, file 319.1–2 (FEC) Far East–1950, HRB.

⁴⁸FEC, Annual Report of Medical Department Activities, 1948, pp. 19–20, RG 112, MMFB; Headquarters and Service Group, FEC, Annual Report of Medical Department Activities, 1948, pp. 9–10, file 319.1–2 (Headquarters and Service Group, FEC) SWPA–1948, Box 497 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB.

Food and sex continued to cause some problems. Americans learned to enjoy Japanese food and found the street stalls and tiny restaurants as interesting as the Japanese. The "continued and seemingly willful violation" of orders placing most of the local food sources off limits resulted in enteric complaints that burdened the medical facilities of the Army. SCAP reaffirmed the ban, but enforcement remained an elusive goal at best. Those other irrepressible vendors, the prostitutes and their pimps, continued to find a market for their wares as well, even though large sections of Japanese communities were put off limits, some brothels were boarded up, and stringent laws against selling sex while infected were passed. The main source of disease shifted to the streets, where privateering professionals or simple pickups were the main danger. Contact tracing of such women proved nearly impossible, and a note of resignation crept into some military reports on the venereal disease problem.⁴⁹

A variety of reasons—the fact that Japan was an island nation, difficulties of transport, care of dependents—ensured a continuing excess of hospitals and bed strength. The abundance of facilities interacted with the shortage of personnel. The Far East Command justified its many hospitals by the lack of personnel, which restricted unit and dispensary service; on the other hand, the hospitals tended to absorb what personnel were available. The fact that medical officers served in hospitals, rarely in the field, fitted in well with the professionalization drive orchestrated by the surgeon general. Yet the result was to make younger officers less capable of meeting their initial tests in field situations.⁵⁰

Hospital service had evolved from a war- to peacetime footing in Japan. The shift from field units to fewer, larger, and more permanent facilities burdened with all the gadgetry of a zone-of-interior hospital was not always smooth. Problems in paperwork and mess management were blamed on the inexperience of Army administrators in running such complex establishments. As inspections and experience solved these difficulties, the early policy of holding patients whose anticipated hospital stay was reckoned at 60 days or less gave way to a 120-day policy, meaning that only the most serious and intractable cases were evacuated to the United States. American forces at first used mainly Japanese Army facilities, but later a building program supplemented the extensive renovation work that was necessary to bring buildings into line with American practices and needs. Patients were transported to the fixed or cantonment-type buildings by train or ambulance and, from remote areas, by air.⁵¹

Ironically, in view of their complaints about cutbacks at home, the surgeon general and his staff soon began to press for reductions in the number of FEC hospitals, transmitting the pressure that they were receiving from Secretary of

⁴⁹Quoted words from FEC, Annual Report of Medical Department Activities, 1948, pp. 35–36, RG 112, MMFB. See also *ibid.*, 1950, p. 63, HRB; 1st Cavalry Division, Annual Report of Medical Department Activities, 1948, pp. 3–5, file 319.1–2 (1st Cavalry Div), Box 575 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB.

⁵⁰Japan Logistical Command (hereinafter cited as JLCOM), Annual Report of Medical Service Activities, 1950, p. 8, file 319.1–2 (JLCOM) Far East–1950, HRB.

⁵¹EUSA, Annual Report of Medical Department Activities, 1948, p. 65, file 319.1–2 (EUSA) 1948, Box 501 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; FEC, Annual Report of Medical Department Activities, 1947, sec. 5, RG 112, MMFB; USAFPAC, Annual Report of Medical Department Activities, 1946, pp. 8–11, RG 112, MMFB.

Defense Louis Johnson. Early in 1950 Deputy Surgeon General Armstrong and the chiefs of the OSG's Hospital and Personnel Divisions visited almost every hospital in Japan. The inspectors found "too many hospitals, too many beds and too many people." Armstrong declared that "the Medical Service in Japan is fine; they are not short of doctors. . . . The hospital buildings in Japan are much better than we have over here." The surgeon general therefore set about doing the same thing for which Johnson would soon be sharply criticized in the United States: reducing the number of hospitals on the eve of war. "They have roughly 14 hospitals in Japan," said Armstrong. "In the Osaka area there are three, recommend one. In Tokyo three, recommend one."⁵²

Colonel Dovell protested that the cutbacks were excessive because the occupation forces were scattered, and the roads poor for purposes of evacuation. Nevertheless, the Far East Command approved a plan to abolish one station hospital, to close the Tokyo Army Hospital Annex, and to reduce four station hospitals to dispensaries. However, action on the plan did not get very far. "It was one of those orders," said Dovell, "that we could not carry out right on the minute anyway, so we kind of dragged our feet." In midyear the thirteen hospitals operating in Japan had a maximum bed capacity of about fifty-four hundred and an average bed occupancy of sixteen hundred.⁵³

In many ways the personnel situation mirrored that of the hospitals. Units complained of an ever-increasing shortage of Medical Department personnel in almost all categories. Enlisted replacements were untrained, and a variety of schools—the Technicians School at Osaka and the Dental Laboratory Technicians School and the Technical Equipment and Maintenance School at Yokohama—sprang up to turn recruits into specialists. Young ASTPs and recent dental graduates needed further instruction, and the Far East Command made haste to bring its own version of a postgraduate training program to the Army's hospitals in Japan.

Worse times, however, were coming. The ASTPs proved to be a godsend in numbers, if not in training, but the last large shipment arrived in September 1948. At the same time, strength in the other corps was often more difficult to maintain than in the Medical. The end of the Korean occupation temporarily brought a welcome influx of personnel, including many doctors, to Japan. The year 1949, however, promised a large and mounting deficit in doctors (*Table 6*), particularly among qualified specialists and in experienced senior officers. This pressure caused the command to shift the work load by reducing elective surgery, evacuating serious cases immediately (though the 120-day policy was not changed), and urging dispensary physicians not to send patients on to the hospitals unless it was absolutely necessary. Medical Service Corps officers were substituted for physicians, where possible, and junior men placed temporarily or permanently in more senior jobs. Civilian doctors were hired in small numbers; the number of Japanese working in the medical installations increased; and

⁵²Quoted words from SG Conference Notes, 27 Feb 50, Medical Collection, HRB. See also JLCOM, Annual Report of Medical Service Activities, 1950, p. 2, HRB.

⁵³Quoted words from Dovell Interv, 21 Sep 66, p.5, HRB. See also JLCOM, Annual Report of Medical Service Activities, 1950, p. 3, HRB.

TABLE 6—ANTICIPATED DEFICIT IN MEDICAL OFFICERS, EIGHTH ARMY, 1949

Month	Officers Assigned	Officers Authorized	Deficit
January	320	357	37
February	324	357	33
March	320	357	37
April	265	390	125
May	139	390	251
June	99	390	291

Source: Eighth United States Army, Annual Report of Medical Department Activities, 1948, pp. 43–46, file 319.1–2 (EUSA) 1948, Box 501 (WW II Admin Recs, 1940–49), Entry 54A, RG 112, MMFB. The deficit was a function of both declining assignments and anticipated increased authorizations, which did not materialize.

enlisted men entered the wards to be trained by Army nurses in basic care of the sick. Physicians were rotated from one subordinate command to another.⁵⁴

As 1950 opened, General Armstrong's view from above ("they are not short of doctors") absolutely contradicted that of Maj. Gen. James A. Bethea, the former FEC surgeon, who had written:

The outlook for medical service within the FEC during the year . . . presents a grim picture from a personnel standpoint. Commencing in January 1950 and increasing each month through June 1950 the losses of Medical Corps officers will be extremely heavy; in fact, so much so that no suitable solution can be foreseen.

The Office of the Surgeon General found and sent sixty residents on temporary duty to tide the command over. By mid-June the last ASTPs were on their way home while the replacements were en route. On the twenty-fifth the Far East Command had a surplus of nurses, almost two-thirds of its Women's Medical Specialist Corps personnel and one-half of its authorized doctors, a shortage of about 10 percent in Medical Service Corps officers, and smaller proportional deficiencies in dental officers and enlisted personnel (*see Table 7*).⁵⁵

The whole command was in similar case, which is one explanation of the surgeon general's recommended cutbacks. An infantry division, some 18,000 strong in wartime, numbered about 12,500 men; combat elements of the Eighth Army were at less than half their normal strength and service troops at a shade over a quarter of theirs. Shortages of medics throughout the divisions of the Eighth Army—the 1st Cavalry and the 7th, 24th, and 25th Infantry—were endurable because the units also were depleted. A minimal medical establishment was keeping on top of the command's problems because the command

⁵⁴USAFAPAC, Annual Report of Medical Department Activities, 1945, pp. 25–26, file 319.1–2 (USAFAPAC, Chief Surgeon's Report, Jun–Dec 1945), Box 496 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; extract from Surgeon's Circular Letter no. 11, Medical Section, USAFPAC, 1 Oct 46, p. 9, HSF (USAFAPAC Circular Ltr–1946), HRB; FEC, Annual Reports of Medical Department Activities, 1947, pp. 105–07, and 1948, pp. 150, 153, RG 112, MMFB; *ibid.*, 1949, pp. 69–70, 74, file 319.1–2 (FEC) 1949, Box 498 (WWII Admin Recs, 1940–49), Entry 54A, RG 112, MMFB; extract from Surgeon's Circular Letter 4, no. 4, Medical Section, FEC, 25 Apr 49, HSF (FEC Circular Ltr–1949), HRB.

⁵⁵Quoted words from FEC, Annual Report of Medical Service Activities, 1950, p. 22, HRB. See also JLCOM, Annual Report of Medical Service Activities, p. 6, and SG Conference Notes, 19 Jun 50. Both in HRB.

TABLE 7—MEDICAL PERSONNEL IN JAPAN, JUNE 1950

Personnel	Authorized	Assigned
Officers		
Medical Corps	318	156
Dental Corps	95	89
Medical Service Corps	309	271
Army Nurse Corps	452	468
Veterinary Corps	15	14
Women's Medical Specialists Corps	31	21
Enlisted Men	5,868	5,600
Enlisted Women	161	132

Source: Japan Logistical Command, Annual Report of Medical Service Activities, 1950, p. 6, file 319.1-2 (JLCOM) Far East-1950, HRB.

itself was understrength, its duties those of peacetime, its environment far healthier than in the early days of the Occupation, and its own health consequently good.⁵⁶

Upon this scene war broke like a thunderclap.

⁵⁶USAFFE and EUSAR, "Logistics in the Korean Operations," vol. 1, p. 3, RG 319, MMHB; Eighth United States Army, Korea (hereinafter cited as EUSAK), Annual Report of Medical Service Activities, 1950, file 319.1-2 (EUSAK) Far East-1950, HRB; Medical Section, FEC, Historical Report, 1 Jan-31 Oct 50, pp. 86-89, Annex XVIII, Medical Section, FEC, file, Box 362 (Staff Section Reports, Annexes XVIII-XXI, Medical-PIO, 1 Jan-31 Oct 50), Entry 429, RG 407, MMFB.

CHAPTER 3

The Medical Service in Retreat

Crossing the 38th Parallel on 25 June 1950, North Korean forces pushed south, scattering the defenders and filling the roads with refugees. As the bewildered dependents of the United States Military Advisory Group arrived in Japan and as the men of the Advance Command and Liaison Group (ADCOM), still in Korea, retreated to Taejon, new American responses to the crisis began to take shape in Washington and Tokyo. American planes bombed the North Korean attackers, and the Far East Command (FEC), having shifted to a war footing, pulled medics from hospitals throughout Japan to fill vacancies in combat units. At Yokohama, where the principal medical depot lay, the Eighth Army hastily cobbled together new field units. Among them was an organization not previously seen in the Far East Command, the mobile army surgical hospital (MASH).

In early July three MASHs were activated: the 8055th on the first, the 8063d on the seventeenth, and the 8076th on the nineteenth. Realizing that forces operating in Korea faced severe problems of transport, the Eighth Army surgeon selected the MASH and its backup, the semimobile evacuation hospital, as his first units because they had their own transport and their complements were small. Little was known about the MASH; though five had existed since the late forties (1948 and 1949), none had seen duty in the Far East. One new MASH commander, rather bewildered by his job, hung out a hand-lettered sign on an unused office in Yokohama and waited for the arrival of his subordinates, most of them as uncertain of their new duties as he was.¹

Yet the concept of the mobile surgical hospital was an old one, dating from World War I, when Americans in France first began to pack both hospitals and mobile surgical teams into trucks with their tentage and equipment. Two successful experiments carried the idea further during World War II. In the Southwest Pacific General MacArthur's staff surgeon devised a portable surgical hos-

¹Dovell Interv, 21 Sep 66, p. 5, Personal Interviews file (Dovell); Interv, Samuel Milner with Lt Col Kryder E. Van Buskirk, MC (hereinafter cited as Van Buskirk Interv), 7 Jul 66, p. 4, AMEDD Oral History file (Van Buskirk). Both in HRB. The five MASHs in existence prior to July 1950 were organized under tables of organization and equipment and were not readily available for deployment to Korea. The Army's make-do response to the Korean emergency is reflected in the organization of the new MASHs under tables of distribution (TDs). These units were created to perform temporary missions and were not intended to see extended service. Many such units were formed during the Korean War and were commonly numbered in the 8,000 series to reflect their assignment to the Eighth Army. It is interesting to note that the Army's TD MASHs survived as long as they did after the fighting stabilized. See Chapter 11 of this volume.

pital to meet the problems posed by the tangled jungles of the region; stripped to its lightest form, hospital gear was carried forward on the human back, down jungle trails where vehicles could not go, accompanied by surgeons chosen for their youth and stamina. In Europe and the Mediterranean another form of forward surgical treatment evolved; field hospital platoons strengthened by special surgical teams worked in tents beside division clearing stations. Both experiments had shortcomings, but both demonstrated an impressive capacity to save lives. A mobile surgical hospital, working close to the front line, could revive and stabilize the severely wounded for their journey to definitive treatment in the rear.

In 1948 the surgeon general issued a table of organization and equipment (T/O&E) establishing a sixty-bed, tented, mobile surgical hospital as a regular and permanent unit of the Medical Department. The T/O&E provided for a headquarters and headquarters detachment, a preoperative and shock treatment section, an operating section, a postoperative section, a pharmacy, an X-ray section, and a holding ward. Fourteen medical officers, twelve nurses, two Medical Service Corps officers, one warrant officer, and ninety-seven enlisted men formed the complement. One medical officer commanded; one was a radiologist; two were anesthesiologists; one was an internist; four were general duty medical officers; and five were surgeons.

This was the theoretical MASH. The real one was somewhat different. As organized at Yokohama, the MASHs were understrength—the 8055th, for example, had only ten doctors and ninety-five enlisted men—and their surgeons were not completely qualified. Indeed, the Far East Command did not have any completely trained and experienced surgeons to assign. Many who served in the MASHs were residents, and many would continue to be, as the surgeon general reached into his teaching hospitals to find young officers for forward posts. “Well,” said the chief of surgery at Walter Reed Army Hospital, speaking of the residents who went to Korea, “there’s only one way to learn good surgery and that’s to get bloody wet.”²

Opportunities to “get bloody wet” were quick to come. On 6 July the 8055th left Sasebo on the USS *Titanian* and arrived at Pusan the same day. Commanding was Maj. Isaac J. Tender, “a short, chunky individual, an extremely active person who ran the unit almost as if it were a one-man show. . . .” The unit immediately entrained for Taejon, where it was to support the 24th Infantry Division. The 8063d left Sasebo on 18 July, headed for Pohang-dong on Korea’s southeast coast, where it made an amphibious landing in support of the 1st Cavalry Division. Arriving in Pusan on 25 July, the 8076th immediately was

²Quoted words from Seeley Interv, 14 Aug 79, sess. 2, cassette 5, p. 11, HSF (Seeley-1947), HRB. See also comments of Col Oral B. Bolibaugh, Orthopedic Consultant, Medical Section, FEC, attached to 8086th Army Unit, Military History Detachment, “The Surgical Hospital in Korea, July 1950–February 1953,” Ms no. 8–5.1A DN, RG 319, MMHB; and Department of the Army Table of Organization and Equipment no. 8–571, 28 Oct 48. On the predecessor hospitals, see Charles Lynch et al., *Field Operations*, The Medical Department of the United States Army in the World War, vol. 8 (Washington, D.C.: Office of the Surgeon General, War Department), pp. 184–205; War Department Table of Organization nos. 284 W, 15 Jun 28, and 8–231, 1 Dec 40, and Table of Organization and Equipment no. 8–570, 21 Aug 1943. See also Smith, *The Medical Department: Hospitalization and Evacuation, Zone of Interior*, pp. 145–46.



SOUTH KOREAN CASUALTIES AWAITING EVACUATION TO THE REAR

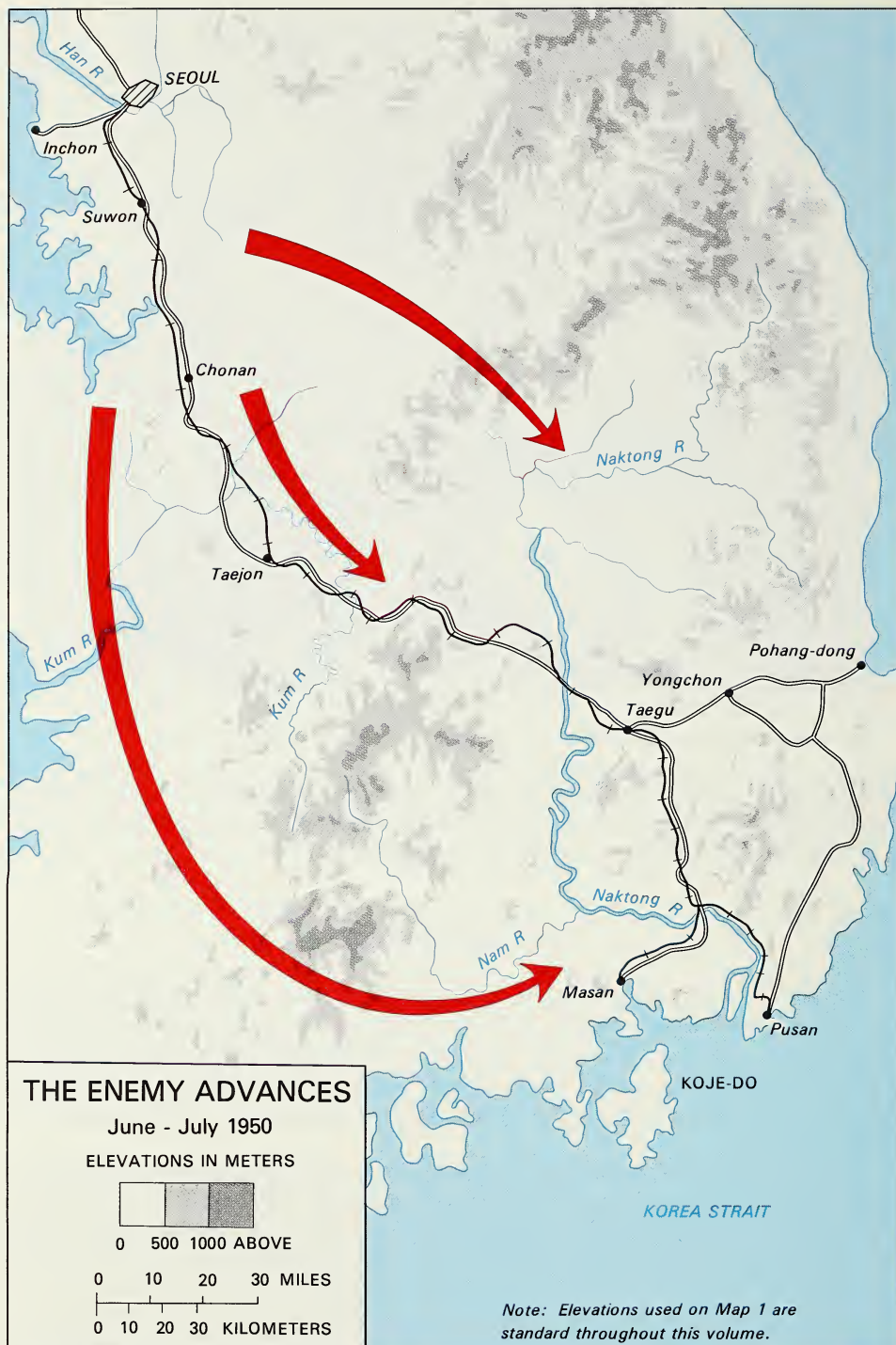
dispatched to support the Eighth Army tactical units fighting in the Taejon-Taegu corridor. By 26 July all the MASHs were committed to battle, amid growing fears of an American calamity in the making.³

Medics in Retreat

Strung along the main road and rail corridor from Seoul to Pusan were a number of Korean towns where Americans died. Below Suwon, where ADCOM had entered, lay Chonan; to the south, Chochiwon, and then Taejon. Beyond Taejon lay Yongdong, with a major center farther to the southeast at Taegu (see *Map 1*). Along this route, fight and fall back was the pattern of the war in the fierce heat of July.

The piecemeal commitment of General Dean's 24th Division began with the airlift of two infantry companies from Lt. Col. Charles B. Smith's 1st Battalion, 21st Infantry. With them went a platoon of recoilless rifles and a platoon from the regimental medical company. Welcomed by festive crowds at Pusan, and

³Quoted words from Interv, Samuel Milner with Lt Col Robert H. Mosebar, MC, 30 May 66, p. 12, AMEDD Oral History file (Mosebar), HRB. See also 8086th Army Unit, "Surgical Hospital in Korea," pp. 2, 28, RG 319, MMHB.



MAP 1



TAGGING AN AMERICAN CASUALTY AT A FORWARD AID STATION

half convinced that the sight of American uniforms would halt the North Koreans, the task force arrived by rail at Taejon on the morning of 2 July. Here they met the men of ADCOM, and Maj. Gen. John H. Church, ADCOM's commander, briefed Smith on the situation. In effect, Smith was to establish a roadblock to delay the enemy and hearten the collapsing South Korean forces. He found a good position on a 300-foot ridge north of the hamlet of Osan, overlooking the Suwon road that penetrated the ridge through a cut with steep embankments. On 4 July, as the Far East Command established the United States Army Forces in Korea with General Dean as commander and Church as his deputy, Task Force Smith, strengthened by howitzers, received orders to take up its position. By 0300 the next morning, in the rain, the men were digging in; the medical platoon, under 1st Lt. Edwin L. Overholt, set up an aid station in the center of the perimeter in a muddy dugout 12 feet square and deep enough to protect against enemy fire.

Between 0800 and 0900 enemy tanks emerged from the continuing rain and pushed through the position, exchanging fire and causing about twenty casualties. The rockets of the Americans' 2.36-inch bazookas bounced harmlessly off the well-armored Russian T-34 tanks. Two were knocked out by howitzers; the rest rumbled on toward Osan. Medics were at work expanding and deepening the dugout and caring for the first wounded when a second and larger enemy force, with both motorized and marching infantry, came into view. Frontal

attacks were thrown back, but as the North Koreans began to envelop the hill, Smith ordered his men to leave the position in groups and to fight their way south. The nontransportable wounded had to be abandoned, two enlisted men volunteering to remain with them. The medics were second off the hill, following C Company. Able-bodied men aided the walking wounded. Lt. Raymond F. Adams, a Medical Service Corps officer who was assistant battalion surgeon and pitcher with the regimental baseball team, dropped a hand grenade accurately on an enemy machine gun firing at the group. Under cover of the railroad embankment, carrying on litters the wounded who could not walk, the party of seventy-five men worked their way through rice paddies and over mountainous terrain some 20 miles to Ansong and safety. For their conduct Overholt and Adams won the Silver Star.⁴

As the enemy drove south, the regimental medical companies absorbed the worst punishment and drew the first lessons of the Korean fighting. Like the MASH, the medical company was a product of postwar reorganization, when the Medical Department sought to apply the lessons of World War II. The idea behind the unit was to lessen the regiment's dependence on the division. The company's three medical platoons followed the regiment's three battalions; each platoon was supposed to have a medical officer as battalion surgeon and a Medical Service Corps officer as assistant battalion surgeon, plus thirty-five enlisted aidmen, litterbearers, and aid station personnel. A collecting platoon contained ambulance, litterbearer, and collecting sections. From battalion aid station to regimental collecting station and thence to division clearing station—a holding facility meant to be supported by a nearby MASH—the chain of evacuation began to take form. But the medical companies bore the brunt. In the fighting north of Taejon one of the most successful but least celebrated units of the Korean conflict began to adapt to a new and harsh kind of war.⁵

Central to the problems faced by regimental medics was the overwhelming nature of the attack. The enemy was tough, brave, acclimated, and well able to mingle with refugees as necessary to infiltrate the defenders' lines. Tactics of armored thrust, combined with infantry assault and envelopment, proved all too effective. The South Korean government never had commanded overwhelming support from its own people; now guerillas moved out of the hills to aid the North Korean attack. Americans were both outgunned and absurdly outnumbered. At one point a journalist, Philip Deane, found a single platoon of thirty-six men guarding a front 3 miles wide. American soldiers proved to be out of condition for fighting on jagged hills in stifling heat; even though salt tablets were sometimes airdropped, the men collapsed from heat exhaustion. Tormented by thirst, they filled their canteens from paddies fertilized with human

⁴The enlisted men were Pfc. Max E. Meyers and Cpl. Ernest A. Fortuna. Both survived three years of captivity, and both were repatriated at the end of the war. This account is based on Roy E. Appleman, *South to the Nakdong, North to the Yalu*, United States Army in the Korean War (Washington, D.C.: Office of the Chief of Military History, Department of the Army, 1961), p. 64; Samuel Milner, "Troubled Decade: The U.S. Army Medical Service in the Post-World War II and Korean Era," ch. 5, pp. 28–34.

⁵Department of the Army Table of Organization and Equipment no. 8–7 N, 6 Jan 48. At this level, Medical Service Corps officers not only performed administrative tasks but also, with proper training and experience, could carry out first aid and make many triage decisions as well.

excrement, adding Halazone (chlorine) tablets of World War II vintage to purify the water. But the Halazone had lost much of its potency, and dysentery soon had attacked a quarter of the division.

As the desperate situation became clear, morale plummeted. Exhaustion, disease, the imminence of death or capture, the repeated defeats hammered at the men and helped to fill the never-ending litters. In the midst of the retreat soldiers remembered that a few days before they had lived the good life in Japan, where they had been conquerors, not conquered. A seventeen-year-old soldier lamented to Deane, "Gee, back in Sasebo I had a car, only a Ford, but a honey. You should have seen my little Japanese girl. Gee, she was a honey. Lived with me in my little villa. It was a honey, my little Japanese villa. Say, got any more of that liquor? Give me a slug, will ya?"⁶

The enemy was indifferent to the Western etiquette of war. Attacks on medical personnel, vehicles and tents became the rule rather than the exception. Capt. Donald L. Duerk's Medical Company, 21st Infantry, was reported "cut to pieces" at Chochiwon. The aid station was the first target of North Korean artillery; enemy riflemen used the red crosses on regimental ambulances as convenient bull's-eyes. The wounded had to be evacuated by tank. After Chochiwon, Duerk's medics painted out the emblem on their equipment and carried M1 rifles. In other action at Chochiwon infiltrators cut off the evacuation of many wounded and captured the battalion surgeon, Capt. Alexander M. Boysen, and his assistant, Capt. Clarence L. Anderson, both of whom were held in captivity for three years. A hospital train leaving Taegu at night for Pusan was hit by fire from rifles or automatic weapons; later, emerging from a tunnel, it was again a target, this time for rifle fire and grenades. As a result, hospital trains had to run in daylight hours, and emergency night runs were guarded by military policemen riding on sandbagged flatcars.⁷

Faced with so many difficulties, the medics learned fast. At Songhwan Capt. Frank D. Thompson, Jr., of the Medical Service Corps learned by experience to place his collecting station of the Medical Company, 34th Infantry, on the main road for quick evacuation, and always "securely within the perimeter of some armed unit."⁸ He spent as much time as possible at regimental headquarters; with equipment to load and patients to move, he had to learn not only what was happening but also what might happen from close-mouthed infantry officers. Thompson ordered aid stations set up in positions accessible to litter jeeps, for the terrain was too rugged, the enemy too active, and the time often too short to permit litter squads to carry the wounded to vehicle loading points. As far as possible, he aimed to keep the stations empty by continuous and rapid evacua-

⁶Quoted words from Philip Deane [Gerassimos Svoronos-Gigantes], *I Was a Captive in Korea* (New York: Norton, 1953), p. 18. See also *ibid.*, p. 20; Appleman, *South to the Naktong*, pp. 180, 262. On Halazone, see extract from 406th Medical General Laboratory Monthly Technical Report, November 1950, HSF (406th Laboratory-1950), HRB.

⁷*Washington News*, 18 Jul 50; *Washington Post*, 19 Jul 50; Milner, "Troubled Decade," ch. 5, p. 43; After-action Interviews With Personnel of 8054th Evacuation Hospital, in Historical Division, EUSAK, "Guerrilla Attack on Hospital Train, 24 August 1950, Near Samnangjin, Korea," Ms no. 8-5.1A BA 101, RG 319, MMHB.

⁸Surgeon's Circular Letter 5, no. 10, Medical Section, FEC, 1 Oct 50, p. 6, file 300.5 (Circular Letters) FEC, HRB.



AMBULANCE DRIVER COVERING THE RED CROSS WITH MUD

tion to lessen the danger that the wounded might be overrun. Much hard work and a measure of luck kept his patients secure until they were evacuated to the rear.

Yet hauling them was difficult, for the roads were rough and snipers common. Overuse broke down the sturdy ambulances, which needed constant care. Like others in similar positions, Thompson placed his collecting station in an existing building, a girls school in Chochiwon that was convenient to the rail-head. Here the medics used and praised the "Doodlebugs," gasoline-powered railroad cars that shuttled from Chochiwon to Taejon, making the 30-mile trip in about forty-five minutes, carrying seventeen litter and fifty ambulatory patients on each trip. Division medical officers felt that one Doodlebug released 4 to 5 ambulances for use elsewhere—an important saving, for ambulances were in hard use and short supply.⁹

By mid-July the enemy had ousted the Americans from Chochiwon, penetrated a defense line along the Kum River, and begun his drive toward Taejon. This southwestern rail and road junction was not, in those days, a good place to live or die. Normally holding about one hundred thousand people, Taejon was

⁹Ibid., pp. 5–10, HRB. See also 24th Medical Battalion, Annual Report of Medical Service Activities, 1950, Encl 6, Ambulance Company Report, file 319.1–2 (24th Medical Bn) Far East–1950, HRB.

flooded with refugees who lived, slept, and performed their bodily functions in the streets. Peasant women staggered along under huge bundles balanced precariously on their heads, and families with weeping children boiled handfuls of grain in tin cans over fires of straw. Here the headquarters and clearing companies of the 24th Medical Battalion arrived on 10 July to find the 8055th MASH already in operation. The two units occupied the Taejon Primary School. Under Maj. Austin C. Doren, the clearing company provided basic hospital services, other than surgery to casualties before sending them to the rear. (The seriously wounded were flown to Japan direct from the Taejon airstrip.) The 8055th MASH, brought with it twelve Army nurses led by Capt. Phyllis M. LaConte. As the worst cases arrived, the clearing company officers sent them directly to the MASH for surgery. Because flight nurses were lacking, Captain LaConte accompanied a trainload of wounded to Taegu and thence, by plane, to Japan.

With great restraint, she reported that work in the primary school was "a new experience for many." To the medics the place seemed fairly orderly, under the circumstances. Journalist Deane saw it with a layman's eyes. The school, he wrote, was a large building whose courtyard was full of vehicles and walking wounded. The smell of disinfectant hung in the air. Inside, litters covered the landings and filled the rooms. Doctors operated in blood-spattered fatigues. "Stitch this, clip that, sponge, stitch, clip, saw—faster, faster, there are more waiting."¹⁰

The nurses were not alone in having new experiences. The medical battalion was severely understrength and its training was spotty. At this time its personnel strength was only 2 or 3 doctors, 3 Medical Service Corps officers, and 124 enlisted men. This was not unusual. The 1st Cavalry and 24th and 25th Infantry Divisions went into combat with 14 medical officers each, instead of the regulation 42, and at no time during the early months of the war did doctors number more than 25 per division. Consequently, sergeants found themselves setting up aid stations and, on occasion, acting as battalion surgeons. In the headquarters of the 24th Medical Battalion the dentists held the administrative posts. The headquarters company had received no field training and "had to learn field operations under actual wartime circumstances. . . ."¹¹

On the other hand, the ambulance company had only recently participated in a field exercise in Japan, was only five men short of its full strength, and had a full complement of vehicles. Operating as far forward as the aid stations, the drivers carried the wounded to the collecting station at Chochiwon, until the town fell; to the Doodlebugs bypassing the station; or, if cases were sufficiently severe, all the way to Taejon. Maps were critically short, and ambulances were destroyed by enemy fire, or lost their way in blackout trips over precarious mountain trails. Snipers' bullets whined out of the darkness in the passes. Yet

¹⁰First quotation from Surgeon's Circular Letter 5, no. 10, Medical Section, FEC, 1 Oct 50, p. 10, HRB. Second quotation from Deane, *I Was a Captive in Korea*, p. 15. See also 24th Medical Battalion, Annual Report of Medical Service Activities, 1950, Encl 7, Clearing Company Report, HRB; Milner, "Troubled Decade," ch. 5, pp. 37, 53; W. H. Thornton, "The 24th Division Medical Battalion in Korea," *Military Surgeon* 106 (July 1951): 12–13.

¹¹24th Medical Battalion, Annual Report of Medical Service Activities, 1950, Encl 5, Headquarters Company Report, p. 3, HRB.



UNLOADING WOUNDED SOLDIERS AT A BATTALION AID STATION

the company suffered no casualties and continued to move the wounded. This was fortunate, for already a durable pattern of the Korean fighting had appeared: Because of the lack of doctors and the few hospitals, a disproportionate burden was thrown upon medical transport of all kinds.

After the penetration of the Kum River line by the enemy, the 8055th MASH and two platoons of the clearing company moved 30 miles south to Yongdong, where they set to work in the agricultural college. One platoon remained at Taejon, operating the station, and a small section from the division headquarters medical detachment ran an aid station at the railroad depot, to assist evacuees on their short ride to Yongdong. Maj. Wade F. Heritage, Surgeon, 24th Division, meanwhile gathered such supplies as he could, radioing for morphine and for "as many litters as possible." One day he took a jeep to drive toward the front. For the last two miles of road, the countryside seemed empty. Then a soldier hailed Major Heritage from a roadside ditch. "Unless you're aiming to desert," he said, "I wouldn't move farther." The enemy was approaching.¹²

First to fall was the vital airstrip, compelling the evacuation of casualties to a secondary strip by motor vehicle. Mortar shells struck among the medics of the

¹²First quotation from Milner, "Troubled Decade," ch. 5, p. 53. Second quotation from Deane, *I Was a Captive in Korea*, pp. 19–20.

63d Field Artillery Battalion. Ferocious fighting began as frontal attacks hit the defensive line. Casualties were massive; at Okchon a battalion aid station exhausted its medical supplies in treating wounded from the Taejon fighting. Whenever possible, wounded were bundled aboard any available plane and flown to Japan, for the slight hospital facilities in Korea were either on the run or could accommodate no more. Soon the clearing company and the 8055th MASH were moving too, the former to Kumchon on the first leg of a retreat that would end only within the soon to be established Pusan Perimeter. The MASH moved to Taegu. Henceforth, it would also do its work within the perimeter.

Captain Thompson's collecting station worked steadily, hauling wounded to the railhead. The remaining platoon of the clearing company joined them. Drivers could rest only while the vehicles were loaded and serviced. At dawn on 20 July an enemy tank rolled down the street in front of the station. Fighting began in Taejon. A round from a tank gun "smashed through a corner of our building and exploded over the entrance to the collecting station," wounding three but killing nobody. The hours that followed were full of "vast confusion and a great deal of gunfire,"¹³ with lulls in which the wounded were carried in. Tank hunter teams, now armed with 3.5-inch bazookas, roamed the city destroying T-34s. General Dean led one of the teams. Later, separated from his men, he found himself behind enemy lines, and was ultimately captured.

At 1600, with most of the wounded already evacuated by train, the 34th Infantry's medical company moved out, its three ambulances loaded with the last of the casualties. Much of Taejon was burning, wires down and streets littered with debris. Outside the town, the convoy was hit by automatic weapons fire from the hills. "It was a matter of running a gauntlet of fire for about three miles," wrote Thompson. "The entire valley was under a pall of dust and smoke from burning trucks." Again and again the infantry cleared the road and the trucks and ambulances continued to move, on into Yongdong.¹⁴

The Pusan Perimeter

With its commodious deep-water harbor, Pusan was the most important point of entry for American forces moving to the Korean battlefields (*see Map 2*). It was also the center of the logistical buildup, its Pusan Base Command the first in a series of headquarters whose prime duties were the maintenance of order, the policing of prisoners, and the storage and movement of supplies. Arriving in Pusan on 6 July, the 8054th Evacuation Hospital, Semimobile, under Lt. Col. John M. Willis, Jr., set up shop in a Korean school. As blood banks opened in Japan, the first shipment of sixty-nine bottles of whole blood in refrigerated marmite cans arrived on the night of the seventh, a few hours before the hospital received its first patients. The 25th Division passed through Pusan

¹³Surgeon's Circular Letter 5, no. 10, Medical Section, FEC, 1 Oct 50, p. 9, HRB.

¹⁴Quoted words from *ibid.*, p. 9, HRB. See also SG Conference Notes, 17 Jul 50, Medical Collection, HRB; Appleman, *South to the Naktong*, pp. 127, 174; Eighth United States Army, Korea (hereinafter cited as EUSAK), Report of ETMD, September 1950, as given in 8086th Army Unit, "Surgical Hospital in Korea," p. 17, RG 319, MMHB.



MAP 2



COL. CHAUNCEY E. DOVELL (*center*) AND THE EIGHTH ARMY MEDICAL STAFF

during 10–15 July on its way to support the 24th Division, then bracing for the enemy's push against the Kum River line. As the provisional capital of the South Korean government, the city was the point around which American and South Korean forces gathered for what might prove to be their last stand on the Korean mainland.¹⁵

The Americans reorganized as Lt. Gen. Walton H. Walker, the Eighth Army commander, assumed control of the Korean fighting and moved his headquarters—now called Eighth United States Army, Korea (EUSAK)—to the Asiatic mainland. With Walker came Col. Chauncey E. Dovell, the able, burly surgeon who headed the Medical Section, and who had given up plans for retirement to take part in the Korean fighting. An officer of the full-blooded sort, Dovell bullied his subordinates, believed himself to be put upon by uncomprehending superiors, and despised rear echelons generally. With Dovell went his deputy, Lt. Col. Charles A. McAllister; his executive officer, Capt. Harry L. Gans, MSC; his supply officer, Capt. Leonard A. Crosby, who also headed operations; WO(jg.) Joseph A. Mikos as administrative officer; and six enlisted clerks under Sgt. Edward A. Peters. The Medical Section set up shop in Taegu in a school, sharing a single room, and the officers bunked together in the chapel. Dovell requisitioned medical units from the zone of interior and pulled still more doctors out of Japan to strengthen the shortage-plagued fighting forces. Under

¹⁵8054th Evacuation Hospital, Semimobile, Annual Report of Medical Service Activities, 1950, p. 3, file 319.1–2 (8054th Evacuation Hospital, Smb1) Far East–1950; 406th Medical General Laboratory, Annual Report of Medical Service Activities, Administrative Section, p. 2, file 319.1–2 (406th Medical General Laboratory) Far East–1950. Both in HRB.

his eye the Korean medical system developed further, though neither its basic problems nor its fundamental means of handling casualties changed.

The shortage of doctors and experienced Medical Service Corps officers remained acute. Triage and transportation continued to take the place of physicians and bed strength. By frequent sorting of the wounded, medics shunted the serious cases either to available hospitals in Korea or direct to Japan. There, however, doctors were also in short supply, and cases requiring services normally performed in forward or communications zone hospitals were sent on instead to the United States. Abuses of the system, some avoidable and some not, appeared; on occasion, men with minor wounds or stress reactions were dispatched to Japan or to the zone of interior. Yet for the wounded, arrival in the United States within ten to fourteen days of the time they fell on a Korean battlefield meant opportunities for definitive treatment that was, for the moment, beyond the capability of the Far East Command.¹⁶

Interviews with casualties indicated the remarkable speed that evacuation sometimes attained. On 21 July, near Taejon, Pvt. Thomas J. Banta of the 34th Infantry, 24th Division, was shot by a sniper in the left arm. A jeep brought him to an aid station; within half an hour a "train" (probably a Doodlebug) took him to the MASH at Taejon. Here he stayed for one day before a plane carried him to Japan, where he received treatment in turn at the 118th Station Hospital and the Osaka and Tokyo Army Hospitals. A week after his original injury he was in Fairfield, California. Doctors there found that a cast on his arm was too tight, the only deficiency noted in his treatment; his general condition was termed "good with some pain." Queried about their experiences, one soldier complained that plane flew too high, making the patients gasp for air; another that medical attendants should have been on his flight to Walter Reed. Another wondered, "Would it be possible to have hot food on board transport planes instead of sandwiches?" But the commonest remark was that of a 25th Division private machine-gunned while evading encirclement at Taejon: "Good treatment all the way."¹⁷

Heavy fighting ensured a continuous flow of casualties. While the 25th Division with its medical battalion faced North Korean thrusts north of Kumchon, the 1st Cavalry Division, supported by its 15th Medical Battalion and the 8063d MASH, waded ashore on 18 July at the little east coast port of Pohang-dong. On 22 July the 1st Cavalry—paradoxically, an infantry unit at this time—relieved the 24th Division, which had suffered 30 percent casualties and had lost its commander. The divisions fought delaying actions, Maj. Gen. William B. Kean's 25th Division troops holding up the enemy for eleven days in a stubborn, bloody defense of Sangju, a town some 40 miles northeast of Taejon.

¹⁶Eighth United States Army, Korea, General Order no. 1, 13 Jul 50, MMFB; Medical Section, EUSAK, Historical Reports, 13–17 Jul 50, Encls 20 to Eighth United States Army, Korea (hereinafter cited as EUSAK), War Diary, files 108 (War Diary–EUSAK, 13–17 Jul 50), Boxes 1082–83 (EUSAK, Section 3, War Diary, 13–16 and 17–20 Jul 50), and Medical Section, FEC, Historical Report, 1 Jan–31 Oct 50, pp. 64–66, file Annex XVIII (Medical Section, FEC), Box 362 (Staff Section Reports, Annexes XVIII–XXI, Medical–PIO, 1 Jan–31 Oct 50), both Entry 429, RG 407, MMFB; Gans Interv, 29 May 66, pp 2–3, AMEDD Oral History file (Gans), HRB.

¹⁷Ltr, Walter Reed Army Hospital to The Surgeon General, DA, 23 Aug 50, sub: Casualty Questionnaire (100 Enclosures), file 704 Casualties (Questionnaire) Korea–1950, HRB.

The clearing company of the 25th Medical Battalion and the MASH, sharing a schoolhouse at Kumchon, were flooded with wounded men. "I'll never forget these casualties," wrote a MASH nurse, Capt. Oree Gregory, in her diary. "In all my 17 years of experience I've never seen such patients, Blind, or with legs or buttocks blown off. Many died despite skilled surgery." The July heat was intense; the flies swarming around the school were "green, large, and heavy."¹⁸

Members of the 25th Division band volunteered to serve as medics at the clearing station. Liaison aircraft, playing a role soon to be assumed by the helicopter, flew fresh whole blood to the MASH and carried some casualties away. The main reliance for evacuation, however, remained the trains. Under-strength, short of drivers, and equipped with ambulances of World War II vintage that required constant repair, the battalion obtained one self-propelled car and three Korean rail coaches and refitted them with crudely built litter racks. The coaches were coupled to supply trains headed for Taegu and Pusan, with orders to the attendants to hitch a ride back in the same way. Familiar difficulties showed up again in the shortage of doctors and the lack of field training, especially severe in the case of the 25th Medical Battalion because, before the war, it had been stationed in the heart of Osaka. Yet the clearing company's thirteen doctors, headed by Lt. Col. Paul C. Sheldon, treated 1,086 patients during July 1950.¹⁹

A new threat now hastened the Eighth Army's withdrawal behind the Nakdong River into what would soon be called the Pusan Perimeter. While the main battle raged on the road and rail corridor, and a lesser one in the Taebaek Mountains and on the east coast where South Koreans stubbornly contested other North Korean forces, the enemy's *6th Division* moved undetected down the western part of the peninsula and by month's end threatened the town of Chinju near the south coast. This flanking movement posed the greatest possible danger to the defending forces: By a sudden thrust through Masan the Communists hoped to capture Pusan itself, cutting off supplies and reinforcements. In consequence, General Walker pulled the battered 24th Division, now under General Church, out of reserve and dispatched it to southwestern Korea. The 25th Division next redeployed to Masan, pushing its way along roads swarming with "carts, A-frames and animals."²⁰ Depleted by the need to support the new front, Eighth Army on the night of 1 August began to withdraw across the Nakdong.

The 8063d MASH left Kumchon on a flatcar, its commander, Maj. Frank A. Neuman, remaining behind with a severely wounded man, who died shortly after. Neuman buried him in the schoolyard, then followed the hospital in the unit's jeep with another doctor and the enlisted driver. At Taegu he rejoined his

¹⁸Diary of Capt Oree Gregory, 23 and 25 Jul 50, as excerpted in Technical Information Office, OSG, "Tokyo to Pusan: An Army Nurse's Diary From the Battlefield" (hereinafter cited as Gregory, "An Army Nurse's Diary," entry date), 13 Mar 51, file 211 (Nurses) Korea, HRB.

¹⁹Medical Section, EUSAK, Historical Reports, 20-31 Jul 50, Encls 20 to EUSAK War Diary, files 108 (War Diary, EUSAK, 20-31 Jul 50), Boxes 1083-87 (EUSAK, Section 3, War Diary, 17-20, 21-23, 24-26, 27-29, 30-31 Jul 50); 25th Medical Battalion History, 20-31 Jul 50, annex 11, 25th Infantry Division History, July 1950, file Book VII (Unit Reports, 25th Inf Div), Box 3747 (25th Inf Div, Supporting Documents, Books V-VII, Jul 50). Both Entry 429, RG 407, MMFB.

²⁰Milner, "Troubled Decade," ch. 5, p. 60.

unit, and both, at Dovell's orders, moved south to Pusan. Here, however, the 8063d soon turned its patients over to the 8054th Evacuation Hospital or the 8055th MASH and moved by rail to support the 25th Division.²¹

Both desperation and hope marked General Walker's defense of the perimeter, an oblong roughly 50 by 100 miles. Fighting was bitter and almost continuous, with heavy casualties rising to a peak during the enemy's climactic assaults of early September. But troop strength was increasing as the 5th Regimental Combat Team, the 1st Provisional Marine Brigade, and the 2d Infantry Division arrived to strengthen the defenders. The 8076th MASH and two hospital ships were now on hand to provide additional medical support. Old methods of evacuation were refined, and a new one, the helicopter, began to take an increasing role in the struggle. Congested with refugees, encircled by battle, the perimeter was also a place of growing strength, assurance, and competence. Anyone viewing the now bustling harbor rightfully could have concluded that, logistically at least, the tide already had turned.

Stabilization of the line enabled preventive medicine officers to reestablish area control over environmental sources of disease. Therapy against malaria had already begun; chloroquine was issued along with Sunday rations, and, in theory at least, administered under supervision to the troops. (Many men, it would seem, failed to receive or else to take the tablets in the stress of battle.) The Far East Command had launched a program to ensure that all personnel moving to Korea received shots against Japanese encephalitis. Temporarily, the flow of refugees that had brought some half a million civilians into the perimeter was shut off by the fighting, enabling harried military and civilian relief workers to get on with the job of providing food, medical assistance, and DDT dustings to the throngs already behind the line.²²

In combat support, medics benefited from the relatively stable line and short evacuation distances. Yet the fierce heat and even fiercer fighting made for heavy casualties, and exhausting effort was required to move the wounded over the steep Korean hills. Each of the regimental medical companies was fortunate to have between twenty-five and fifty Korean soldiers who served as litterbearers. During the fight west of Masan, Capt. Arthur P. Wickstrom, surgeon of the 35th Infantry, reported that six men were needed to carry a single litter down Battle Mountain (Hill 665), plus medics to administer aid during the long haul and riflemen to protect the party from enemy snipers. Capt. James A. Ball and Capt. Ernest M. Bradley, surgeons of the 17th and 24th Infantry regiments, respectively, drew similar pictures. This pitiless warfare that spared no one complicated the medical problem, which already was sufficiently great.

To the rear of the fighting line the 25th Division clearing station was set up in Masan's city hall. Here Lt. Col. Herbert C. Wallace, the division surgeon, was in charge. Malaria, heat exhaustion, and psychiatric problems as well as battle and nonbattle injuries swelled the flow of patients. The seriously wounded were sent on to the 8063d MASH in nearby Changwan, or to the hospitals in Pusan. Another of the invaluable self-powered railway cars shuttled between the clear-

²¹Neuman Interv, 28 May 66, p.5, AMEDD Oral History file (Neuman), HRB.

²²For a fuller treatment of these topics, see Chapter 10 of this volume.

ing station and the MASH, only 3.5 miles away, and Air Force helicopters, an innovation rapidly gaining ground in Korea, supplemented wheeled transport to Pusan. The MASH, as usual, occupied a schoolhouse, a building singularly verminous even for Korea. A nurse recorded that the windows in her quarters, where nurses slept seventeen to a room, had to be shut tight in the stifling heat to exclude the rats. Wounded jammed the building. As Captain Gregory recorded in her diary,

We have patients in every place—every known type of wound and burn—men of all ages and from all walks of life. One private had lost an arm and was likely to lose a leg. He wanted to be the first to let his mother know. . . . All the men have bloodstained letters they never had time to read. They're begging for water. But they're mostly due for surgery, so fluids are limited. After that was explained, they just accepted it. Sometimes when they heard our voices, the boys would think they were back in the States. One private said: 'My God! Not a real American nurse! Take off my bandages so I can see her!' But he was blind.²³

Under Maj. Kryder E. Van Buskirk, the 8076th MASH had meanwhile established itself in a woolen mill at Miryang, convenient to the central part of the front and the units that fought there—the 24th Division (later relieved by the 2d Division) and the 1st Marine Provisional Brigade. Additionally, because the other MASHs were now located to the south, casualties from the 1st Cavalry Division also reached the 8076th. Fortunately for its overburdened staff, the Marine brigade surgeon with five or six Navy doctors and thirty hospital corpsmen joined forces with them. Van Buskirk later recalled that

during this time . . . the 8076th had its finest hour. Everybody worked around the clock without orders of any kind. Indeed, it became Van Buskirk's duty as MASH commander to point-blank order people to bed. There was no end to the work. You would work 24 hours pretty well straight through. The next day, you would nap between cases. You would go to sleep at midnight, and sleep till you were needed and someone woke you up, and the cycle would start all over again. The nurses would work every bit as hard. Most would work 12 to 16 hours a day without rest and some until they collapsed.

Supply problems added to the difficulties of front-line surgery. Though the 8076th never lacked for blood, it was usually short of sponges, bandages, sutures, and surgical knives. Bandages and sponges had to be washed and rewashed; nurses would "give the doctors hell if they so much as wasted a suture."²⁴

Handling more patients than the other two MASHs combined, the 8076th at Miryang had a collective style that reflected the attitudes of its commander. Alone of the EUSAK medical units, the MASH did not send its nurses away

²³Quoted words from Gregory, "An Army Nurse's Diary," 8 Aug 50, HRB. See also Appleman, *South to the Naktong* pp. 369–70; 25th Medical Battalion, Annual Report of Medical Service Activities, 1950, p. 5, file 319.1–2 (25th Medical Bn) Far East–1950, HRB; 35th Infantry Regiment War Diary, 1–31 Aug 50, in 25th Infantry Division History, August 1950, file Book VIII (25th Inf Div, War Diaries, Unit Reports), Box 3750 (25th Inf Div, Supporting Document, Book VIII, Aug 50), Entry 429, RG 407, MMFB; Milner, "Troubled Decade," ch. 5, p. 63.

²⁴Quotations in this and the following two paragraphs from Van Buskirk Interv, 7 Jul 66, pp. 4 and 11–13, HRB.

when danger became acute; Van Buskirk argued that the hospital could not operate without them, and if a situation was too dangerous for the nurses, it was too dangerous for the MASH. Periods of all-out work alternated, whenever possible, with relaxation, as the commander did not believe in looking busy when there was nothing to do. Accomplished scroungers, the MASH people seemed to acquire equipment wherever they lingered; the well-equipped marines, for example, left Van Buskirk a 220-volt generator and a walk-in "electric reefer [refrigerator] mounted on a truck," while "similar goodies" were picked up by other MASH officers. By his own admission Van Buskirk was not averse to good whiskey, and he maintained a "very liberal" policy for both officers and men. When times were easy "the thing to do was to play, to relax—a philosophy that he strictly observed in running his MASH."

The style of mingled competence and casualness suited the nature of the hospital's professional staff. The MASH had only ten doctors including its commander; of those, seven had just finished internships. Yet these same seven had served as enlisted men in World War II, and, according to Van Buskirk, "practically all of them had served as infantrymen of the line." They might be new doctors, but they were, like Van Buskirk himself, old soldiers, and performed accordingly.

Backed up by the hospitals at Pusan and in Japan, the clearing stations and the MASHs provided a successful system of emergency medicine. For the few medics there, the costs were exhausting work and sometimes needless evacuation. Improvised in the course of a few weeks, the system met the needs of the hour while establishing patterns that were to last through much of the Korean conflict.

The Other Side of the Line

North Koreans also were mortal, received wounds, and needed aid. The nature of their medical service affected the outcome of the battle and, by contrast, threw a sharp light upon the achievements of the United Nations (U.N.) forces. Structured on Russian models, the North Korean medical service showed up well in organization charts that provided for medical personnel in line outfits; for hospitals; and for separate medical units. Division medical battalions, regimental medical sections, battalion medical detachments, and company aidmen in theory formed an imposing array. But serious practical weaknesses existed in the quality of the personnel and in materiel. Medical equipment was a mix of Russian, Japanese, and captured American implements and drugs. By and large, the quality of medical officers was poor. Communist "cultural officers," whose mission was to assure the political reliability of the army, apparently produced ill-feeling because they tended to view doctors as intellectuals, a class about whom Stalinist ideology entertained dark suspicions. Despite some contradictory evidence, POWs generally reported that the supply system, though it continued to deliver ammunition and weapons even during U.N. air attacks, failed as early as July to provide adequate food to the troops.

Medical and morale problems resulted. Evacuation and treatment of the wounded were also seemingly poor.

But North Korean units differed markedly from one another. By late August some elements of the *1st Division* had fought for as long as eight weeks, cut off from their sources of supply. POWs reported a diet of two or three riceballs a day, supplemented by food seized or proffered by captured villages. Yet their physical condition was better than their history suggested. American intelligence officers judged that "the modest wants of the Korean soldier, the practice of foraging off the country-side, and the high morale engendered by initial successes probably compensated for the effects of the physical privation." In the *2d Division*, by contrast, POWs unanimously declared that the physical condition of the men had seriously deteriorated by the end of July; all complained of undernourishment and extreme fatigue. In the *6th Division*, the desertion rate was reported by a prisoner to be "very high," as was the death rate among the wounded. "There were no doctors in the division," interrogators concluded, "and only two medical aidmen to each battalion." Men seriously wounded were evacuated but reportedly received little treatment in the rear. Those lightly wounded were given first aid and returned to the front lines. "Lack of medical attention" was reported a source of discontent in the *9th Division*, and a cause of surrender among men who feared death if they were wounded.²⁵

Indeed, conditions among the enemy wounded reportedly were dismal. Infection was a fact of life on both sides. Even U.N. soldiers arrived in hospitals with "most wounds . . . grossly contaminated with field dirt," leaves of rice plants and crumbs of human excrement plainly visible in some of them. Wounded North Korean prisoners of war showed the same problems in exaggerated form, their injuries "frequently infested with hordes of maggots." Lack of immunizations must have accounted for the seventy-five active cases of tetanus seen among POW patients at the 8054th Evacuation Hospital, in marked contrast to the almost total absence of tetanus among U.N. personnel. By September and October, when masses of prisoners came in, many of their wounds were "old, having been treated in North Korean hospitals," and 90 percent were grossly infected, many "dressed with leaves or with old paper."²⁶

Another indication of the enemy's medical failings was the systematic looting of South Korean facilities, poor as these were. Nearly all the South Korean hospitals were commandeered for the invaders' use, and a large number of South Korea's eighteen hundred to two thousand doctors were impressed into the invading army. In mid-September the North Korean government ordered complete stripping of all hospitals as its forces retreated. Instruments, blankets, drugs, even dressings were removed and carried north. On the whole, the im-

²⁵First quotation from Intelligence Summary no. 2905, 23 Aug 50. Second and third quotations from Intelligence Summary no. 2910, 28 Aug 50. Fourth quotation from ATIS Interrogation Report no. 949, 11 Sep 50. All in Encl 7 to Weekend Letter no. 7, Maj Gen Edgar Erskine Hume, Chief Surgeon, Medical Section, FEC, to Maj Gen Raymond W. Bliss, Surgeon General, DA, 27 Oct 50. See also ATIS Advance Echelon Report no. 0030, 10 Oct 50, in Encl 4 to Weekend Letter no. 13, Hume to Bliss, 2 Jan 51. Both in file 200 (Personnel Letters Between SGO and Medical Section, FEC), Box 3099 (Medical Section, FEC, General Records, 1950), RG 338, MMFB.

²⁶8054th Evacuation Hospital, Annual Report of Medical Service Activities, 1950, pp. 6-7, HRB.

pression left by North Korean medical practice was one of tragic poverty. At the same time, American surgeons and commanders complained of ghastly conditions in South Korean Army hospitals, where basic measures of cleanliness were neglected and ill-trained doctors ruthlessly carried out amputations. In this respect, there was little practical difference between the two Koreas. Both halves of the nation bore the marks of their common history during recent centuries as a poor and excluded people.²⁷

The effect of all this on the course of battle is largely a matter for educated conjecture. By common agreement the generally excellent care provided U.N. soldiers was essential to their morale, which tended to slump in any situation, such as Battle Mountain, where slow evacuation or other factors reduced their chance of survival. (A study of one hundred American casualties in August indicated that 88 percent received medical aid of some sort within two hours of wounding.) The contrast between the two armies was great.

Yet American casualties were lost to further service by hasty evacuation, as the North Koreans were by incapacity or death. The American forces (and their allies, such as South Koreans serving with American units and other U.N. forces who also were treated by American hospitals) had the kind of medical system they required in order to function successfully. The North Koreans lacked such a system, functioned gallantly without it, and failed in their great gamble because of losses—estimated by some analysts at 4 to 1, during the Naktong offensive—that no medical service could have restored to duty in time and in sufficient numbers to make it succeed.²⁸

The Medical System Takes Form

The U.N. system was evolving rapidly. As in most wars, very few things in Korea worked exactly as Army planners had foreseen. Typical was the transformation of the MASH during its harsh introduction to battle. Intended to support one division, to handle only the most serious cases, and to forward its patients as soon as possible to an evacuation hospital equipped to hold them, the MASH found every one of these principles reversed. Each MASH had to support more than one division, and its range of clients grew as the U.N. forces—the United Nations endorsed the defense of South Korea during July, member nations pledged support, and the first British forces arrived during August—grew in numbers. As usual, the tactical forces increased faster than the support troops, and by year's end the 8055th MASH reported that its operating room had worked on British, Turkish, Filipino, Greek, Thai, and Dutch fighting men; on Americans from the 1st Cavalry and the 2d, 24th and 25th Infantry

²⁷Summary Intelligence Report no. 2982, 7/8 Nov 50, in Encl 4 to Weekend Letter no. 13, Hume to Bliss, 2 Jan 51, RG 338, MMFB. Dovell spoke of "amputating geniuses" in South Korean hospitals who "were in the habit of chopping off legs, arms, feet, whatever else was in the way, with a great deal of gusto." See Dovell Interv, 21 Sep 66, p. 9, HRB.

²⁸Appleman, *South to the Naktong*, p. 310.



SOUTH KOREAN CASUALTIES RECEIVING MEDICAL ATTENTION *at the South Korean Army Hospital in Taejon*

Divisions; on Korean civilians; and on prisoners of war. Because only one evacuation hospital was available, and transport was poor and overburdened, the MASH quickly developed into an all-purpose hospital, treating both sick and wounded, though the condition of its laboratories and its lack of medical specialists caused it to ship the ill as quickly as possible to other facilities. In effect, the MASH became a small evacuation hospital and its bed strength, instead of the regulation 60, fluctuated with need. From the 8076th MASH Capt. Elizabeth N. Johnson reported in August that "we are anything but a 60-bed mobile surgical unit. Our holding wards alone have held 200 patients."²⁹

Whether they worked in the MASHs or elsewhere, young doctors by most accounts had a hard time adapting to the battlefield. Colonel Dovell recalled that the first nine physician replacements to arrive in the Eighth Army informed him that the job they were best qualified to perform was tissue pathology. In

²⁹Quoted words from Ltr, Capt Elizabeth N. Johnson, Chief Nurse, [?] MASH, to Chief, ANC, as excerpted in Technical Information Office, OSG, "Army Nurses in Korea—Background Information," 24 Aug 50, file 211 (Nurses) Korea, HRB. The formal conversion of the MASH's table of distribution and allowance that occurred later in the year changed its bed strength from 60 to 150–200. See 8086th Army Unit, "Surgical Hospital in Korea," pp. 2, 9–14, RG 319, MMHB.

reply he assured them that they would make good battalion surgeons, and eight actually did so. The ninth, on his first encounter with war, went "wild as a jackrabbit. . . . We had to evacuate him that same day as a psycho." In after years, the officer who was chief of surgery at Walter Reed during the Korean War recalled the words of a medical officer who had served there. "I don't want ever to be caught again as ignorant as I was about the conduct of the Medical Department activities in a theater of war and not know what to do," the physician averred. "I was strictly a professional man and I just wasn't capable."³⁰

Among surgeons, clinical retraining as well was essential to "unlearn . . . the very excellent and beautiful principles necessary in civil practice" in favor of "the rapid and adequate sort of care of massive wounds, massive trauma." There were too few surgeons, and those mostly young with much to learn. Neurosurgeons and orthopedists were, and remained, in short supply. Yet on the battlefield, orthopedic injuries—especially compound comminuted fractures (crushed or shattered fractures accompanying wounds)—were the commonest of all. As a result, both types of wound further burdened the transport system, neurosurgical cases going to a center established in Japan.³¹

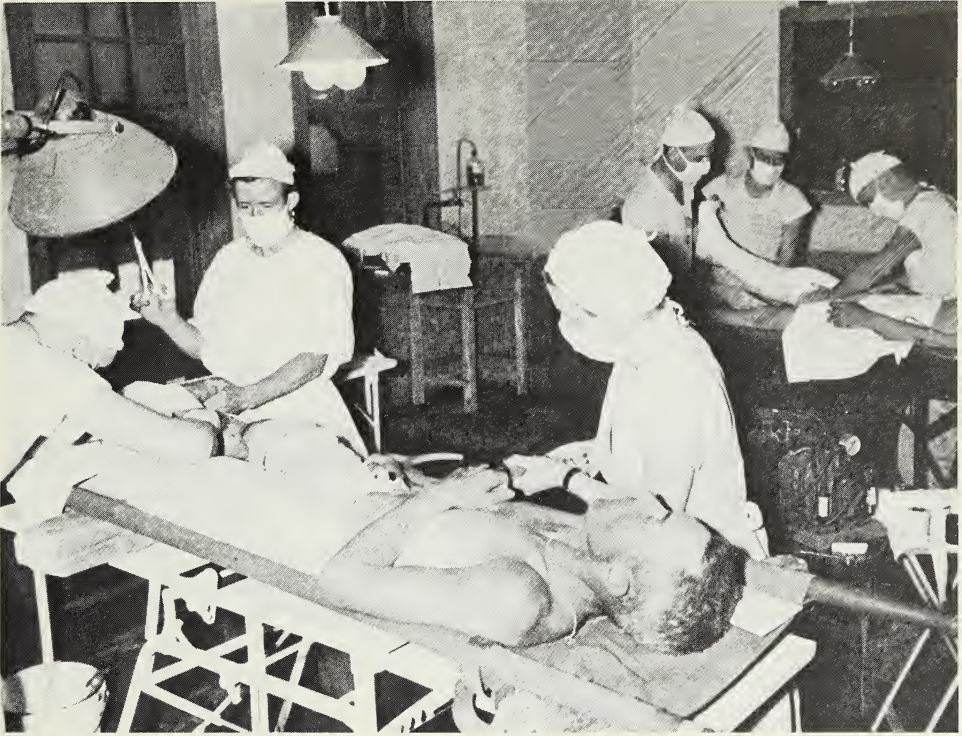
The surgeons who succeeded in mastering their new jobs—most did—learned to perform the brisk, decisive interventions required by a flood of massive traumas in a septic environment. A surgeon following Eighth Army rules would approach an abdominal wound in this way. He first performed a "bold para-median incision," a vertical cut extending from 3 inches above the navel to 3 inches below. Entering the peritoneal cavity, he arrested any visible bleeding. He then completely eviscerated the patient and examined the mesentery—the tissue holding the intestines to the abdominal wall—for bleeding vessels, which he ligated. He marked and clamped intestinal perforations to prevent further contamination, performed the necessary suturing or resections of the bowel, cleaned out any oddments of breakfast that had gotten loose—"wandering pork and beans, floating bits of canned chicken, errant chunks of hot dog"—replaced the viscera, and sewed the patient up.³²

Sometimes the surgeon encountered surprises. At the 8076th MASH in Miryang during the perimeter battles, a surgeon working in the belly of a Korean soldier felt something crawling into his glove. "I got out of there fast," he admitted. In time operating room personnel learned to be casual about the phenomenon. Every Korean, said Capt. Genevieve A. Connors, a surgical nurse at the 8055th MASH, "had a belly full of worms, and as soon as you opened it, they would start crawling out. They would be better than a foot long and would move slowly, rather like angle-worms in sidewalk puddles after a heavy rain." Worms crawled into and blocked nasogastric tubes. She recalled how she dealt

³⁰First quotation from Dovell Interv, 21 Sep 66, p. 11. Second quotation from Seeley Interv, 14 Aug 79, sess. 1, cassette 1, p. 32. Both in HRB.

³¹Quoted words from Seeley Interv, 14 Aug 79, sess. 2, cassette 5, pp. 11–12, HRB. See also FEC, Annual Report of Medical Service Activities, 1950, pp. 35–38, file 319.1–2 (FEC) Far East–1950; EUSAK, Annual Report of Medical Service Activities, 1950, pp. 62–64, file 319.1–2 (EUSAK) Far East–1950. Both in HRB.

³²First quotation from EUSAK, Annual Report of Medical Service Activities, 1950, p. 62, HRB. Second quotation from W. L. White, *Back Down the Ridge* (New York: Harcourt, Brace, 1953), p. 91.



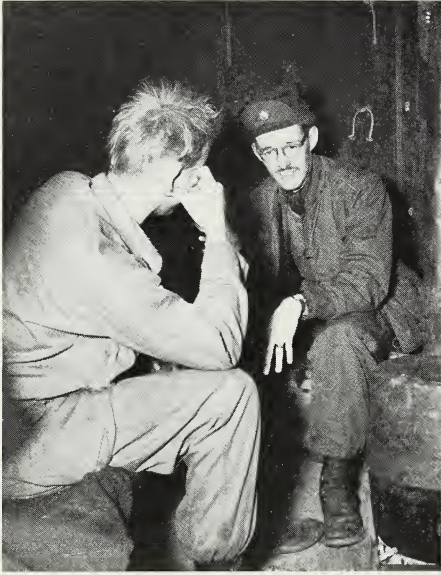
SURGEONS AT WORK IN TAEGU

with them: “As they crawl out, all you do is pick them up, drop them in a pail and go on [working].”³³

Similar in some ways to the surgical story were the initial errors in the handling of neuropsychiatric cases (NPs) during the early months of the conflict. NPs were common during the retreat when exhaustion, despair, and the fear of encirclement shattered the morale of many men and some units. They reached a high point in September, precipitated by the heavy North Korean assault. A variety of factors contributed. Many veterans of World War II felt that the Korean fighting was more intense than any they had known. The landscape of denuded hills gave a feeling of “no place to hide,” and the process of fighting up one hill only to be confronted with another beyond was psychologically as well as physically wearing.

Throughout the early months, failures by both commanders and medical officers amplified psychiatric losses. The basic lesson learned in World War I and relearned in World War II—that men suffering from symptoms of battle fatigue should be held as close as possible to the front line—was, partly from necessity, forgotten. Men with mild nonpsychotic symptoms were hustled aboard planes or ships and dispatched to Japan, the worst possible treatment because it took a soldier from the line and taught him the lesson that escape

³³As related in White, *Back Down the Ridge*, p. 95.



FIELD PSYCHIATRY

from danger was the reward for bizarre behavior. The result was the loss of many men who, with a few days rest, a sedative, and a hot meal, could have returned to duty.³⁴

With the formation of the Pusan Perimeter, the psychiatric admission rate soared, from 50 cases per thousand troops per year in July to 258 in August. These figures accompanied a general improvement in American morale and battle performance and provided a sharp commentary on the single most notable failing of the Medical Service during the early months in Korea. In part, the problem continued to be a simple lack of bed space; overwhelmed by casualties, the few Korean hospitals could not accommodate all of the combat fatigue cases. Between July and December 1950 the 8054th

Evacuation Hospital evacuated 85 percent of its NPs and returned only 15 percent to duty, reversing normal expectations.

The major exception to this generally gloomy picture tended to prove the rule. In the 2d Division a vigorous effort was made from the first days of battle (about 10 August on) to hold NPs at the clearing station level, where most "could be dealt with by . . . a few days rest and returning them to duty." When the division surgeon arrived in Korea on 19 August, he brought with him a qualified psychiatrist, Capt. Martin J. Schumacher. During the first week of September, Schumacher set up a neuropsychiatric treatment center—outside the existing regulations, which provided for no such establishment—with equipment borrowed from the 2d Medical Battalion and from the division's Special Services. The center operated at Miryang only during September, after which the division went over to the attack. Then movement made the holding operation impossible, while at the same time the psychological lift of advancing helped to make it unnecessary.

During September, however, when the 2d Division engaged in fighting as hot as any along the perimeter, out of its 612 NPs 71 percent were returned to duty and only 29 percent evacuated. Many of the division's men were newcomers who faced the stress of battle suddenly and among strangers. As a result, the ratio of NPs to wounded almost doubled the World War II norm. Schumacher's success in salvaging a large proportion of such losses underlined the need for dealing rationally with the consequences of stress.³⁵

³⁴United States Army Forces, Far East (hereinafter cited as USAFFE), Annual Report of Medical Service Activities, 1953, p. 49, file 319.1-2 (USAFFE) Far East-1953, HRB.

³⁵Above three paragraphs are based on 2d Infantry Division, Annual Report of Medical Service

Command failures continued to bear some responsibility for the commoner picture of heavy neuropsychiatric losses. One of the leading psychiatrists in the Eighth Army was assigned to work as a venereal disease officer rather than in his clinical specialty. Other contributing factors were beyond the power of commanders to control. Young and inexperienced men working as battalion surgeons had to make many difficult triage decisions, and inevitably made some poor ones. The record of the hospitals, too, was generally bad. The combination of retreat, bad command decisions, inexperienced doctors, quick evacuation, and lack of bed space caused combat psychiatry to founder. Its failures weakened the Army in Korea at a time when manpower losses were critical.³⁶

Besides psychiatry, the medical system in Korea had another basic problem. Emphasis on strictly professional training had provided many new personnel neither field experience nor the type of wide, cursory, but essential knowledge of many kinds that combat demanded. The problem showed itself in many forms, among enlisted men as well as officers. The 2d Division surgeon wrote:

Experience in the present conflict indicates [a] necessity for reinstating a basic medical department officer's course in which administration and tactical aspects of field operations are presented to every medical department officer during the early years of his service. Similarly, the present concept of strictly compartmentalized career . . . planning of enlisted medical department personnel, is not conducive to a well-rounded, capable, jack-of-all-trades enlisted man. This is especially true of non-commissioned officers who have received their rating since the Career Management Program had been instituted. This is not an attempt to belittle or decry the specialist technician whether he be x-ray, dental, etc., but merely to point out that the overall efficiency of a unit would be greatly benefitted if the technician possessed in addition to this specialist knowledge, the well-rounded experience and background found formerly in the 'old' Medical Department non-commissioned officer.³⁷

Enter the Helicopter

Not only men and organizations but machines as well showed the impact of experience in Korea. Few technical innovations were equal in importance to the growing use of the helicopter for medical evacuation. A product of World War II, the helicopter early had attracted the surgeon general because of its potential as an evacuation vehicle. In 1947 the Medical Department had studied the

Activities, 1950, p. 17, file 319.1-2 (2d Inf Div) Far East-1950, HRB. In October the number of NPs fell by three-fourths; the proportion evacuated was about the same.

³⁶Surgeon's Circular Letter 6, no. 3, Medical Section, FEC, 1 Mar 51, pp. 48-52, file 461 (Circular Letters) FEC; Surgeon's Circular Letter 5, no. 10, Medical Section, FEC, 1 Oct 50, p. 19. Both in HRB. See also 8054th Evacuation Hospital, Annual Report of Medical Service Activities, 1950, p. 9, HRB; Albert J. Glass, "History and Organization of a Theater Psychiatric Service Before and After 30 June 1951," in *Recent Advances in Medicine and Surgery Based on Professional Medical Experiences in Japan and Korea, 1950-1953*, Medical Science Publication no. 4, 2 vols. (Washington, D.C.: Walter Reed Army Institute of Research, [1955]), 2:365-66. Before his death, Dr. Glass prepared a complete clinical history of psychiatry in the Korean War, which is on file at the Center of Military History.

³⁷2d Infantry Division, Annual Report of Medical Service Activities, 1950, p. 29, HRB.



LOADING A CASUALTY ON A MARINE CORPS HELICOPTER

possibility of an Army evacuation squadron to serve under the surgeon of a field army. In Korea, however, the Air Force was the first to use helicopters for evacuation. In late July 1950 a detachment of the 3d Air Rescue Squadron arrived in Korea under the command of Capt. Oscar N. Tibbetts. Its primary mission was to recover downed pilots. But the rapid decline of the North Korean air force meant that the detachment's job was not very burdensome. Tibbetts began to receive and answer requests from Army units to rescue casualties who could not be reached by ambulance. By August 1950 the unit was answering so many calls that "it found itself in the medical evacuation business."³⁸

Colonel Dovell was intensely interested in the helicopter. He requested an Air Force helicopter on loan for a test. On 3 August, in the schoolyard of Taegu Teachers College, amid "some telephone poles and a couple of old buildings that were still standing," the Sikorsky touched down, blowing dust that stung like powdered glass into the eyes of the onlookers. Loaded with two litters behind the pilot's seat, and additionally burdened with Dovell's bulky form, the helicopter flew without trouble to the 8054th Evacuation Hospital in Pusan.³⁹

³⁸8086th Army Unit, Military History Detachment, "Helicopters in Korea, 1 July 1951-31 August 1953," Ms no. 8-5.1A AJ, RG 319, MMHB.

³⁹Dovell Interv, 21 Sep 66, p. 14, HRB.

Dovell began to press for Army helicopters to work under his own control and soon received support from his superiors. General Hume, the FEC surgeon, became an enthusiastic backer. In October Surgeon General Bliss visited the Far East Command and spent several hours closeted with General MacArthur discussing medical problems. He reported to his staff that "MacArthur feels that helicopters should be in the T/O&Es and should be a part of medical equipment—just as an ambulance is." With such strong support, the Office of the Surgeon General requested two helicopter ambulance companies of twenty-four small craft each. By 20 October definite word had come from the port of San Francisco that eight helicopters were being purchased for immediate airlift to the Far East Command. Meanwhile, four detachments of four copters each were being activated for medical use. "This," noted the staff, "will make General Hume very happy for this apparatus is badly needed."⁴⁰

With all its remarkable implications for the future of Army medicine—indeed of emergency medicine, whether military or civilian—the rapid adoption of helicopter evacuation resulted from the nature of the Korean conflict and of the Korean countryside. The broken terrain separated fighting units from their medical support. The poor road net, the prevalence of guerillas, and the North Korean tactics of infiltration and envelopment contributed to the problem. Because roads were few, traffic was forced onto a few main routes that enemy artillery could interdict; overuse made the roads worse; and their form—"extremely narrow, sharply winding, and steep in ascent and descent"—imposed much added suffering upon the wounded. Early in the fighting, a passenger in an ambulance wrote that the vehicle "tears along, bumping fit to break the chassis. Speed is vital. . . . But it is also essential not to bump the wounded more than can be helped. Which is to come first? . . . The driver serves both masters as well as he can." By contrast, the smoothness of the helicopter's ride prevented many hemorrhages and reduced the danger to men with head and spinal cord injuries. Finally, the rotary-winged aircraft was swift, and speed as much as its ability to land in a constricted area or the smoothness of its flight made it an ideal vehicle for the movement of the wounded.⁴¹

From the beginning of its career the medical evacuation helicopter was associated with the MASH. Its normal route of travel was from the aid station or clearing station to the surgical hospital, bearing the critically wounded (the so-called nontransportables) to immediate, often radical stabilizing treatment. Typical of the early days was the experience of the 2d Division surgeon, Col. Donald E. Carle, with helicopter evacuation. The division was the first to arrive in Korea direct from the United States, debarking at Pusan 10–20 August and moving to Miryang, site of the 8076th MASH as well as of the division's own forward command post. On 1 September, as the enemy's "Great Naktong Offen-

⁴⁰First quotation from SG Conference Notes, 10 Oct 50. Second quotation from *ibid.*, 15 Nov 50. Both in HRB. See also EUSAK, Annual Report of Medical Service Activities, 1950, pp. 8, 69–70; FEC, Annual Report of Medical Service Activities, 1950, pp. 114–15. Both in HRB.

⁴¹Quoted words from Deane, *I Was a Captive in Korea*, p. 14. See also Spurgeon H. Neel, "Medical Considerations in Helicopter Evacuation," cited in 8086th Army Unit, "Helicopters in Korea," pp. 28–31, RG 319, MMHB; 24th Infantry Division, Annual Report of Medical Service Activities, 1950, p. 2, file 319.1–2 (24th Inf Div) Far East–1950, HRB.

sive" hit the line, Carle contacted Colonel Dovell at Eighth Army and asked for helicopter evacuation. Two machines—it is unclear where they came from—were placed at his disposal and stationed near the command post. The division surgeon then dispatched them on call to the various clearing stations, but only for patients whose head, chest, or abdominal wounds made evacuation by field ambulance undesirable. The helicopters, too fragile and too scarce to be risked, were not allowed to evacuate battalion aid stations, or even regimental collecting stations, "due to their vulnerability to small arms fire."⁴² Their contribution was qualitative—to bring the worst cases to the MASH in the first hours after wounding.

Clearly, the helicopter was only beginning its career in medical evacuation in the summer of 1950. The machines that were available belonged to the Air Force, the Marine Corps, or the Air Section of Eighth Army headquarters. Most patients were, and would continue to be, moved by train or ambulance. Yet the new link to the century-old evacuation chain in time would transform the system radically and, in wars to come, would make the chain itself at least temporarily obsolete.

At no time was medical evacuation the only use for helicopters. Resupply, troop deployment, and use as a command vehicle early claimed many helicopters, for all the problems that beset the medics in the Korean countryside also afflicted the line. A status symbol for commanders, available machines too often were taken (as Dovell complained) by "generals and top brass . . . for their personal use." Amid many jobs by many branches of the Army and by the Air Force, helicopter pilots found opportunity to perform medical evacuation on return flights. Yet it was the medical function that attracted the most attention. The sheer spectacle of the flights, the lives hanging in the balance, the noisy, dust-flailing arrivals and departures stamped an unforgettable image on the minds of onlookers and led to a contemporary judgment that "the most dramatic and most publicized employment of helicopters in Korea was their use in evacuation of combat casualties."⁴³

For all the changes beginning to emerge from the Korean experience some things remained the same. Most basic was the courage of people, unarmed or little trained in the use of arms, who either brought casualties out or worked to save them. Company aidmen, battalion surgeons, collecting and clearing station personnel, MASH surgeons, and many others withstood the pressures, bore the dangers, and on occasion lost their lives aiding the wounded. At Chonui, a hamlet north of Chochiwon, Pvt. Jack Bolen of the Medical Company, 21st Infantry, won the Distinguished Service Cross for conspicuous heroism; Pvts. Ronald R. Dusek and Donald V. Bailey—the first a company aidman, the second a battalion ambulance driver—won the same award at the defense of the Kum River line. Near Changnyong on 6 September, Pfc. Richard L. Fleischmann, an aidman with a machine gun platoon of Company H, 23d Infantry, 2d Division, first pulled two wounded men to safety and then took their place at

⁴²2d Infantry Division, Annual Report of Medical Service Activities, 1950, p. 2, HRB.

⁴³Quoted words from Dovell Interv, 21 Sep 66, p. 16, HRB. See also 8086th Army Unit, "Helicopters in Korea," p. 16, RG 319, MMHB.

the gun until killed. He, too, received the Distinguished Service Cross. And medics were not the only ones to risk their lives. At Taejon Sgt. George N. Libby of the Corps of Engineers won the Medal of Honor posthumously for his feat in aiding a tractorload of wounded to run an enemy roadblock. No doubt for each recorded instance of bravery, the deeds of many others will forever escape the notice of history.⁴⁴

By mid-September General Walker's defense of the perimeter appeared likely to triumph. After a month of almost continuous fighting, the North Koreans at last conquered Battle Mountain. But the defenders turned back the three main enemy thrusts of the September offensive—in the south at Masan, in the east around Pohang-dong, and in the center at the approaches to still unconquered Taegu. Though fighting in the area was not over, the war by this time had taken a new and startling turn that ended the bitter months of retreat and siege. Following their comrades of the line, some medics already had gone over to the attack.

⁴⁴Eighth United States Army, Korea, General Order no. 50, 3 Sep 50, MMFB; Appleman, *South to the Naktong*, p. 173; Clark C. Munroe, *The Second United States Infantry Division in Korea, 1950-1951* (Tokyo: Toppan Printing Co., 1952), p. 21; Department of the Army General Order no. 62, 2 Aug 51, PAB.

CHAPTER 4

The Medical Service in the Attack

General MacArthur's experience in the Pacific war combined with Korean geography to make an amphibious attack against the enemy rear an early possibility. Commanding the sea and air, and well able to strike the Korean peninsula at many points along its lengthy coast, United Nations (U.N.) planners also were aware of the fact that the Communists had committed almost all their forces to the attack on the Pusan Perimeter. Staff studies began during July and August. The proposed strategy was to counterattack, but several times the shortage of troops and heavy enemy pressure against the Eighth Army delayed action.

At last, on 6 September, MacArthur confirmed the fifteenth of the month as D-day for a landing against Inchon, the port of Seoul. A commercial city whose military importance lay in its proximity to the capital, Kimpo Airfield, and the main north-south transport corridor, Inchon presented an altogether different kind of objective from the Pacific Islands of the Second World War. Described by a Marine Corps officer as "about the same size and general attractiveness as Jersey City, New Jersey," Inchon, like the capital beyond, was packed with civilians whose wounded would become charges of the Medical Service. The 30-foot-plus tides troubling that portion of the Korean coastline also posed evacuation problems. To meet the many difficulties of the landing, MacArthur established X Corps under his chief of staff, Maj. Gen. Edward M. Almond. Spearheaded by the 1st Marine Division, Almond's force had the 7th Infantry Division as its main Army component. With X Corps, a strong infusion of fresh medical units entered Korea to meet the needs of a new front in the three-month-old war (*Table 8*).¹

Medical Support for the Invasion

The hasty assembling and equipping of the invasion force—primarily at Kobe, Sasebo, and Yokohama in Japan, and Pusan in Korea—brought the usual

¹Quoted words from Robert D. Heinl, Jr., *Victory at High Tide: The Inchon-Seoul Campaign* ([Annapolis, Md.]: Nautical & Aviation Publishing Company of America, 1979), p. 25. Except as otherwise noted, the general account of this campaign is from Appleman, *South to the Naktong*, pp. 488–776.

TABLE 8—NONDIVISIONAL MEDICAL UNITS IN KOREA, AUGUST 1950

Eighth Army	X Corps
8055th MASH	1st MASH
8063d MASH	121st Evacuation Hospital, Semimobile
8076th MASH	4th Field Hospital
171st Evacuation Hospital, Semimobile	6th Army Medical Depot
8054th Evacuation Hospital, Semimobile	Advance Platoon
64th Field Hospital	Blood Distribution Section
6th Army Medical Depot	150th Veterinary Food Inspection
8065th Army Medical Depot	Detachment
38th Malaria Control Detachment	163d Medical Battalion (Separate)
207th Malaria Survey Detachment	559th Medical Ambulance Company
66th Veterinary Food Inspection	560th Medical Ambulance Company
Detachment	618th Medical Clearing Company
95th Veterinary Food Inspection	(Separate)
Detachment	421st Medical Collecting Company
476th Veterinary Food Inspection	(Separate)
Detachment	
461st Dental Prosthetic Detachment	
52d Medical Battalion (Separate)	
567th Medical Ambulance Company	
(Separate)	
514th Medical Clearing Company (Separate)	

Source: Far East Command, Report of ETMD, August 1950, p. 2, file 350.05 (FEC) 1950, HRB. The Eighth Army absorbed the X Corps in December 1950.

quota of mix-ups worsened by a natural calamity. As field units arrived from the zone of interior, their equipment turned up piecemeal on the docks. The Japan Logistical Command (JLCOM) discovered that, instead of being combat loaded, the materiel had been dispersed through many ships. Only the reserve medical assemblies already on hand in Japan enabled all units designated for the landing to be ready in time.

The old problem of assuring an adequate supply of drinkable water took a new turn. Municipal supplies at Inchon were not likely to remain potable once the fighting started. When the engineers reported that no distillation units were available, the Medical Section, Far East Command (FEC), experimented with transporting water in Japanese oil tankers. This last-minute decision set off frantic activity. Workmen scrubbed and decontaminated the tanks, covered them with cement wash, and filled them with lightly chlorinated water. At sea the expedient quickly failed, for seawater or oil from leaks in the ships' own machinery invaded several tanks. Medical units around Inchon later reported "many hardships . . . in regard to [the] supply of water," and the chief cause of illness among the troops was gastroenteritis.²

²Quoted words from 4th Field Hospital, Annual Report of Medical Service Activities, 1950, Sanitary Service sec., Water Supply, file 319.1-2 (4th Field Hospital) Far East-1950, HRB. See also *ibid.*, Patient Status sec.; JLCOM, Annual Report of Medical Service Activities, 1950, p. 11, file 319.1-2 (JLCOM) Far East-1950; FEC, Annual Report of Medical Service Activities, 1950, p. 79, file 319.1-2 (FEC) Far East-1950. All in HRB. Gastroenteritis is a general term denoting inflammation of the stomach and bowel; diarrhea often results.

Adding to the normal problems of loading a large force on short notice, Typhoon Jane thundered into Kobe harbor on the morning of 3 September. A storm surge, driven by winds of 110 miles per hour, swept across cargo-laden piers. Cranes toppled, ships broke loose from moorings, and equipment was soaked and scattered. As winds abated in the afternoon, port troops and the 1st Marine Division faced "exhausting and dangerous work" to secure drifting vessels and to reassemble, dry, and load essential cargo.³ Yet the fleet sailed on time.

Early on the fifteenth, under a lowering sky, the marines landed on Wolmi, an island off Inchon harbor. On the evening of the same day they scaled the Inchon seawalls and began to move inland. Behind them came 7th Division forces. Hard fighting began as initially weak enemy resistance stiffened, and both military and civilian casualties mounted. Medical units were reported ashore on D+2. Soon both the Navy medics who accompanied the marines and those of the Army had their work cut out for them.⁴

The organization of the Army medical effort grew directly out of the planning process for the invasion. Meeting in Tokyo, the Far East Command's Joint Strategic Plans and Operations Group included a medical section, and on 26 August, when X Corps was organized, this section became the office of the corps surgeon, Col. Alvin L. Gorby. A tall, heavysset man, capable and well-liked, Gorby at one time had been favored by General Hume to become the Eighth Army surgeon. Because General Walker preferred Dovell, Surgeon General Bliss sought to have Gorby appointed as the JLCOM surgeon. But if Walker had not wanted Gorby, Almond did, and he refused to release him. Gorby found himself serving for four months as the surgeon of an independent corps, "a position," said Hume, "hardly less important than that now held by Dovell."⁵

Gorby's authority, too, resembled Dovell's in the Eighth Army. Though he commanded only the personnel of the Medical Section, X Corps, he provided policy and guidance to all corps medical units. Additionally, several operated directly under corps headquarters, including the 4th Field Hospital, the 121st Evacuation Hospital, Semimobile, and the 163d Medical Battalion (Separate). This battalion was actually a headquarters detachment whose staff of six officers, one warrant officer, and sixteen enlisted men coordinated the activities of a number of separate units that had been attached to it in Japan—a collecting and clearing company and two ambulance companies. With the 7th Division's medics and the 1st MASH, attached to the division, these units provided the backbone of X Corps medical care.⁶

³Appleman, *South to the Naktong*, p. 501.

⁴TELECON 202100Z Sep 50 TT 3792, sub: Routine Medical Matters, file 024 (Telecon Communications Between OTSG, Washington, and FEC) 1950, HRB.

⁵Ltr, Maj Gen Edgar Erskine Hume, Chief Surgeon, FEC, to Maj Gen Raymond W. Bliss, Surgeon General, DA, 4 Sep 50, file 312.3 (Correspondence-SGO-Washington), Box 3106 (Medical Section, FEC, General Records, 1950), RG 338, MMFB.

⁶See X Corps, 4th Field Hospital, 121st Evacuation Hospital, Semimobile, and 163d Medical Battalion (Separate), Annual Reports of Medical Service Activities, 1950, files 319.1-2 (X Corps), (4th Field Hospital), (121st Evacuation Hospital, Smb), and (163d Medical Bn, Sep) Far East-1950, HRB. On 26 December 1950 X Corps became a tactical corps of the Eighth Army.

Led by MacArthur's chief of staff and more than adequately supplied, the invasion force was known to the hard-fighting Eighth Army as the "Gilded Lily." However, there was nothing cushiony about the struggle that developed on the approaches to Seoul. During the early phase of the fighting, casualties were light among the marines and the soldiers that followed them. As the enemy dug in for a last-ditch defense, Marine losses soared.

Meanwhile, Army units struggled into position and sought to open a usable route of evacuation. After nightfall on 19th September the 7th Medical Battalion came ashore on LSTs at Yellow Beach, the divisional landing area. Marching through darkness to an assembly point, the men bedded down in abandoned buildings to await their equipment. But the Inchon tides intervened; three days elapsed before the battalion's vehicles were unloaded. On the twenty-second a platoon of the clearing company plus an ambulance platoon moved out to support the 32d Regimental Combat Team, setting up shop in a deserted brewery in Anyang-ni. The Marine hospital took the company's evacuees, but as fighting intensified it became full to overflowing. Now the medical battalion evacuated to the beach where the medical detachment of 2d Special Engineer Brigade had set up as shore party, receiving wounded and loading them on LSTs for transport to the hospital ship USS *Consolation*, which was anchored off-shore. Again the tides intervened, causing long waits for the wounded on the dismal beach.

The fall of Kimpo Airfield on the twenty-first opened a new route of evacuation. Again supply planes received the injured for return flights, and Japan was once more providing backup to the Army and Navy hospitals in Korea. During the first fifteen days of fighting, 870 patients were carried to the hospital ship and 1,271 flown out of Kimpo.⁷

Then General Almond grew impatient with the marines, halted by the desperate defense west of Seoul. On 25 September the 32d Regimental Combat Team crossed the Han River and joined the encirclement of the capital. A platoon of the 7th Medical Battalion's clearing company supported the advance. Though street fighting was now raging in parts of Seoul and its suburbs, the North Koreans stripped the city of most of its doctors and medical supplies. Hundreds of injured men, women, and children flooded the clearing station, even as military casualties were increasing. Problems multiplied because enemy artillery and sniper fire, as usual, did not spare the medics. Another platoon moved in to assist. Civilian injuries were severe, with many traumatic amputations and complex surgical cases. Clearing station personnel, at work in a schoolhouse, turned over one wing to the civilians, provided medical supplies and supervision, and found two Korean doctors and two nurses to bear the brunt of the work. An officer with a party of thirteen enlisted men entered Seoul to organize civilian medical facilities there. Withdrawal of the enemy main

⁷X Corps, Annual Report of Medical Service Activities, 1950, pp. 1-7, HRB. For the story of Navy medics serving the marines, see U.S. Bureau of Medicine and Surgery, *The History of the Medical Department of the United States Navy, 1945-1955*, NAVMED P-5057 (Washington, D.C.: Government Printing Office, 1958), pp. 126-35.

forces, rapid evacuation of U.N. casualties, and the efforts to organize civilian relief brought some improvement in the situation. By the end of the month, fighting on the 7th Division front had almost ended, and the South Korean government once again controlled its capital city.⁸

Behind the fighting line the hospitals found themselves facing a similar mix of wounded soldiers, civilians, and, as the tide of battle turned, increasing numbers of prisoners of war (POWs). The men and women of the 1st MASH clambered down the side of the USS *General W. A. Mann* on 16 September into small boats "in what seemed," said a nurse "to be mid-ocean." Ashore at Incheon, the hospital secured its favorite shelter in an abandoned and "pretty awful" school building and attempted to start work minus its equipment, which had been shipped separately. Nevertheless, makeshift wards opened, mainly for civilians and POWs, using borrowed Marine equipment. An advance group of the 121st Evacuation Hospital, which had sailed with the invasion convoy to provide medical care for the troops, already had established a temporary hospital for civilians, working under almost impossible conditions with virtually no supplies at all. Taking over this task, the 1st MASH treated some three hundred civilians, most of them wounded and burned. Among the patients were a substantial number of children who, when the hospital was ordered up to support 7th Division, had to be consigned to Christian orphan homes.⁹

Meanwhile, the two larger hospitals also had opened. After landing on the twenty-fifth, the 4th Field Hospital moved to a site in Ascom City. Here, damaged by bombs and shellfire, stood abandoned buildings, once officers' quarters for the Republic of Korea (ROK) Army. The parade grounds were overgrown with brush and small trees. Hired labor quickly cleared the area and repair crews made the buildings serviceable. With steam heat, electricity, and movies at night, the hospital now enjoyed conditions of relative comfort. A onetime service club served as the main hospital building. Evacuees from forward aid stations and direct admissions arrived by ambulance convoys and by helicopter. Additionally, a substantial number of sick and accident cases helped to fill the wards.

A wide range of services reflected the hospital's growth. The surgical service handled primarily abdominal and chest wounds. The medical service spent much of its time fighting a near epidemic of bacillary dysentery plus outbreaks of hepatitis and malaria. A psychiatric service operated separate wards and provided the typical pattern of brief directive therapy and rest, with evacuation only for the seriously disturbed. The average length of hospital stay for neuro-

⁸7th Medical Battalion, Annual Report of Medical Service Activities, 1950, pp. 3-4, file 319.1-2 (7th Medical Bn) Far East-1950, HRB.

⁹Quoted words from Ltr, Maj Eunice Coleman, Chief Nurse, 1st MASH, 15 Nov 50, as excerpted in Technical Information Office, OSG, "Background Information: Army Nurses in Korea" (hereinafter cited as Coleman, "Army Nurses in Korea"), 2 May 51, file 211 (Nurses) Korea, HRB. See also 1st MASH, Annual Report of Medical Service Activities, 1950, p. 1, file 319.1-2 (MASH, 1st Army Unit) Far East-1950; 121st Evacuation Hospital, Annual Report of Medical Service Activities, 1950, p. 3. Both in HRB.



KOREAN CIVILIAN HOSPITAL AT INCHON, *operated by the 1st MASH*

psychiatric patients (NPs) was two to three days, with 65–70 percent returning to duty—a marked improvement over the conditions of the Pusan Perimeter a month earlier. Though the front eventually moved as much 200 miles ahead of the hospital, NPs found small reason to prolong their illness in “a Field Hospital shorn of luxury, in a town devoid of much beauty.”¹⁰

As often happened in Korea, the 4th Field Hospital’s bed strength increased with little regard to its table of organization and equipment (T/O&E). With some one thousand beds, with additional equipment and bedding supplied by the medical and quartermaster depots, and with its varied services and permanent location, it rapidly evolved, for practical purposes, into a station hospital or a small general hospital serving the installations and units of the Seoul-Inchon area.

On the other hand, the 121st Evacuation Hospital retained its basic character during its brief stay near the capital. Primarily devoted to treating X Corps personnel at the town of Yongdung-po, the hospital aided about six hundred patients before its departure on 8 October. The staff achieved marked success with medical and surgical patients, but less with the psychiatric. Apparently the

¹⁰4th Field Hospital, Annual Report of Medical Service Activities, 1950, Neuropsychiatric Service sec., para. 7, HRB.



4TH FIELD HOSPITAL IN ASCOM CITY

atmosphere of an evacuation hospital, with its clear suggestion that the next stop was Japan, was not a good one for NPs; additionally, the facility lacked privacy for the treatment of such cases. For a few days in late September the hospital also treated six hundred POWs, the first wave of a massive influx which, during late October, was to impose a heavy additional burden on the 4th Field Hospital as well.¹¹

The X Corps soon moved in pursuit of the fleeing enemy. Despite its location on the west coast, the corps did not invade North Korea by this route. Instead, its hospitals barely had time to unload their belated equipment when orders arrived for a second planned invasion, this time on the east coast. On 6 October, the day when its equipment at last left the ships, the 1st MASH was attached to 7th Division and began to load up to join the medical battalion at Anyang-ni. The part of the invasion fleet they were rejoin lay 350 miles to the south, in the harbor of Pusan. The fact that hospitals could move overland, through areas recently held by the North Koreans, reflected an extraordinary fact. The enemy army in South Korea had virtually ceased to exist.

¹¹Above paragraphs are based on *ibid.*, 1950, HRB. See also 4th Field Hospital Command Report, September 1950, file MDFH-4 (Command Report, 4th Field Hospital, 25 Jul-Sep 50), Box 4715 (Nonorganic Units, MDDP-4 to MDGH-457, 1949-50), Entry 429, RG 407, MMFB.

Medics in the Breakout

MacArthur's plan called for the Eighth Army to break out of the Pusan Perimeter on 16 September. The main thrust was to aim toward Taejon along the well-worn invasion corridor. Chances for success were better than even the planners in Tokyo, misled by overestimates of enemy strength, had imagined. Outnumbering their foes by as much as 2 to 1, and aided by tactical air support and by naval gunfire along the coast, the U.N. forces were a far cry from the battered troops that had retreated southward in July. Yet the first two days of fighting were confused and indecisive, with North Korean attacks continuing even as the counterstroke was launched. (The great news of the day—the successful invasion at Inchon—was known to U.N. troops but not to most of their foes.) But on 18–19 September a general enemy withdrawal began, veiled by sometimes desperate rearguard actions. Not until days later did the cumulative effects of heavy losses, the news of Inchon, and Eighth Army victories produce widespread disintegration in enemy units. Then the retreat turned rapidly into a rout.

For medics the first effect of the breakout was a surge of wounded, the second a tumultuous advance that brought new problems in handling casualties. Simultaneously the influx of wounded POWs rose sharply, burdening tactical units and hospitals alike at a time when their supply lines were overextended. Yet frequent moves, intermittently heavy work loads, and the continuing dangers posed by enemy stragglers and brigands in the devastated countryside could not dampen the elation of the time. Victory seemed to be at hand.

Division medics experienced the full range of battle, breakout, and pursuit. Toward the southern end of the perimeter, the 2d Infantry Division scored one of the earliest successes, driving the enemy into the Naktong River and securing a beachhead for its own forces on the western side. Here the 38th Infantry captured a large bag of prisoners, including thirty-two female nurses. By 22 September what the 2d Medical Battalion's commanding officer called "the race northward" had begun. On the twenty-eighth the division command post stood at Anui, on 1 October at Chonju, on the ninth at Suwon, and the following day opened in the technical college at Seoul. Through these changes of station, covering hundreds of miles by the twisting Korean roads, division evacuation routes shifted frequently. When the move to Anui placed the clearing station outside the range of helicopters flying from Pusan, a division L-5 fixed-wing



A MEDIC IN THE BREAKOUT

reconnaissance plane was reserved for evacuating the seriously wounded. From Chonju the division was able to send its casualties to the 8063d and 8076th MASHs, themselves on the move. When it reached Seoul, the division evacuated to the 4th Field Hospital in Ascom City. Medical supply was at first maintained by leaving a section at the Miryang railhead; the rest of the supply personnel moved forward with the division headquarters. At Chonju the supply officer reunited his people, and by October the division was able to draw upon an advance section of the 6th Army Medical Depot, then issuing supplies at Ascom City.¹²

Variations on this story reflected the differing experiences of other divisions. Once the pursuit began, the 24th Medical Battalion found casualties "extremeley [*sic*] light" and its main duty to "keep up with the rapidly advancing combat elements." Ruined rail lines made evacuation a problem, and for a time long ambulance hauls to a terminal at Waegwan, northwest of Taegu, became necessary. Wounded North Koreans meanwhile "descended on the Clearing Stations in what appeared to be a never ending stream." Forward combat elements carted POWs in by the truckload, many in appalling condition with long-neglected wounds that the clearing stations were not equipped to treat. With resupply already a problem such patients drained the medical supplies on hand and left little for future emergencies. Wounded civilians also appeared, and because no other treatment was available to them, they were not turned away. Whenever possible, the battalion secured the services of Korean doctors and nurses for their suffering countrymen. Battalion members established civilian hospitals, staffed them with the best local help available, and attempted to supervise the work. Begun in South Korea, the same methods were applied in the North after U.N. forces crossed the 38th Parallel. In such homely ways the immense job of providing medical relief in the newly liberated areas began even before the fighting had ended.¹³

The experiences of 25th Infantry Division medics were somewhat different. When the breakout started, the division advanced rapidly from its old battlefields near Masan to Taejon, scene of the first major U.N. defeat in July. Division medics moved by the well-established technique of leapfrogging the clearing station platoons, one remaining to care for casualties until the others had moved ahead and opened in a new location. After its arrival at Taejon, however, the 25th Medical Battalion suspended its travels for a month (7 October to 6 November), while the division cleaned up enemy pockets left behind in the pell-mell advance. With few casualties to care for, the medics spent most of their time in training and in repairing and replacing lost and damaged equipment. The battalion then moved astride the 38th Parallel, with one clearing station at Kaesong below the line and one at Kumchon above. On 19 November the unit again moved out by motor convoy to support a renewed offensive.¹⁴

¹²Quoted words from 2d Medical Battalion, Annual Report of Medical Service Activities, 1950, p. 2, file 319.1-2 (2d Medical Bn) Far East-1950, HRB. See also 2d Infantry Division, Annual Report of Medical Service Activities, 1950, pp. 13-14, file 319.1-2 (2d Inf Div) Far East-1950; Appleman, *South to the Naktong*, 548-51.

¹³24th Medical Battalion, Annual Report of Medical Service Activities, 1950, file 319.1-2 (24th Medical Bn) Far East-1950, HRB. All quotations from Encl 7, Clearing Company Report.



UNLOADING CASUALTIES FROM A DUKW *at a Nakdong River crossing*

Almost bewildering were the movements of the MASHs as they sought to maintain close support of the advance to and across the parallel. "The month of October," wrote a nurse with the 8055th, "proved how mobile a Mobile Surgical Unit can be." During that month the 8063d advanced from Chinju near the Korea Strait via Taegu, Taejon, Ascom City, Kupaballi, and Sariwon—the last in North Korea—to Pyongyang, some 300 miles by air and much further over the twisting roads. The 8076th moved from its base at Miryang about 240 miles to the northwest to Haeju, a North Korean town on the Yellow Sea. The itinerary of the 8055th was more complex still. During the perimeter battles the "Double Nickel" had moved to Pusan but, even before the breakout, had returned to provide forward support at Taegu, the embattled anchor at the northwestern corner of the U.N. line. After the breakout the 8055th shifted to Kumchon on the twenty-seventh and to Taejon on the thirtieth. At Taejon the

¹⁴25th Medical Battalion, Annual Report of Medical Service Activities, 1950, especially pp. 2–3, file 319.1–2 (25th Medical Bn) Far East–1950, HRB.

¹⁵Quoted words from 1st Lt Nan L. Porter, ANC, "History of the 8055 Mobile Army Surgical Hospital, October 1950" (hereinafter cited as Porter "History"), in 8055th MASH Monthly Historical Report, 1–31 Oct 50, file MDSU–8055 (Historical Report, 8055th MASH, Oct 50), Box 4717 (Nonorganic Units, MDSU–1 to MGGP–304, 1949–50), Entry 429, RG 407, MMFB. Except as otherwise indicated, all information on the 8055th MASH is from this source. See also MASH chronologies and maps in 8086th Army Unit, Military History Detachment, "Surgical Hospital in Korea," pp. 28–43, Ms no. 8–5.1A DN, RG 319, MMHB.

MASH took over a hospital building, the first it had occupied in Korea. Formerly a facility of the United States Military Advisory Group to the Republic of Korea, the structure resembled a one-story Army cantonment hospital with connecting wards and quarters. A total cleanup was needed, which hospital personnel finished "just in time to pack and move north again." The patient load was small, however—accident victims for the most part, and casualties wounded unintentionally, some when trash fires set off unexploded ordnance. Evacuation to and from the hospital was entirely by air, either because of its availability and a small patient load or, more likely, because the trains were not yet running to Taejon.¹⁵

Taejon, the town where the 8055th MASH had begun its battlefield service in July, now wore a new and grim aspect. On their retreat the North Koreans had massacred thousands of soldier and civilian prisoners, including at least forty Americans. "The dead," Colonel Dovell recalled, "who included children as young as 18 months and women over 80, had first been buried up to the neck, and then dispatched by being hit over the head, apparently to save ammunition." Bodies had been thrown into wells that emitted a terrible stench; when water was drawn out, "pieces of human tissue are found therein." Hospital medics who visited the scene returned deeply impressed by "the terrors of war and the fanaticism of the enemy."¹⁶

On 4 October, with the arrival of elements of the 64th Field Hospital in Taejon, the 8055th MASH—leaving its nurses behind for safety—advanced to Kupaballi, a town 10 miles north of Seoul. From Kupaballi, the MASH took a long, dusty ride of 125 miles that included a period of tedious waiting to cross a single-span floating bridge over the Han River into Seoul. Here the hospital occupied the customary wooden frame schoolhouse, while most of the men lived in tents in the yard. Patients continued to be few, most from vehicle accidents in the north-bound convoys. The MASH evacuated by ambulance to the 121st Evacuation Hospital at Seoul and later to the 4th Field Hospital at Ascom City. Six days of light work ended as the 8055th MASH split and leapfrogged to Kaesong, only 5 miles south of the 38th Parallel, along roads lined with burned villages and the wrecks of enemy tanks. North Koreans still were resisting north of the line, a field artillery outfit was ambushed, and operating rooms ran twenty-four hours a day. Helicopters and L-5s flew the most serious cases to Ascom City; the others endured a 72-mile ambulance ride over rough roads. By now the nurses had rejoined the unit. They left Seoul in ambulances, huddling at the rear windows to stare at the city, "a mass of wreckage and debris."¹⁷

The invasion of North Korea impended. On 7 October the United Nations debated the question of crossing the parallel, approving at last a resolution

¹⁶First quotation from Dovell Interv, 21 Sep 66, p. 12, Personal Interviews file (Dovell), HRB. Second quotation from Ltr, Maj Gen Edgar Erskine Hume, Chief Surgeon, FEC, to Maj Gen Raymond W. Bliss, Surgeon General, DA, 30 Oct 50, file 312.3 (Correspondence-SGO-Washington), Box 3106 (Medical Section, FEC, General Records, 1950), RG 338, MMFB. Third quotation from Porter "History," in 8055th MASH Monthly Historical Report, 1-31 Oct 50, RG 407, MMFB.

¹⁷Porter "History," in 8055th MASH Monthly Historical Report, 1-31 Oct 50, RG 407, MMFB.



ENEMY SOLDIER RECEIVING FIRST AID *near Han River crossing*

allowing MacArthur to invade, if he deemed it necessary. In fact, the determination of the South Korean government to reunite the country and the momentum of the U.N. drive made any other outcome most unlikely. In the eastern part of the peninsula the ROK I Corps struck along the coast of the Sea of Japan toward the North Korean port of Wonsan. The ROK Army in quick, hard thrusts disrupted the enemy defense and advanced an average of 15 miles a day. In the central mountains the ROK II Corps advanced more slowly through harsh terrain against slight enemy resistance. In the west the recently formed American I Corps, with its attached British, Australian, and Philippine units, relieved X Corps in the Seoul-Inchon area. At noon on 7 October the 4th Field Hospital shifted over to the Eighth Army. I Corps troops swept the enemy from the area north of Seoul and, on the ninth, crossed the 38th Parallel (*see Map 3*).

Shortly afterward the 8055th MASH followed. On the eighteenth, half the hospital moved to Sinmak, a town on the main road through Kaesong about 70 miles north of Seoul, becoming the first Eighth Army hospital to cross the parallel and its nurses the first to enter North Korea. Reunited, the MASH had to set up tents around an airstrip, for "there was no building left anywhere."¹⁸ As a cold, wintry rain fell on the medics, the nurses knew that their efforts back at Taejon to round up long johns and other winter gear from the 24th Infantry

¹⁸Ibid.



MAP 3

Division were not in vain. For the first time large numbers of enemy POWs poured into the 8055th, while the number of U.N. casualties remained small. Evacuation was easy, carried out from the airstrip at their doorstep.

Between the twenty-first and twenty-third, the hospital moved in the familiar leapfrog fashion into the enemy's capital of Pyongyang. Again, as at Seoul, ponton spans replaced bombed bridges and "dust, mud, traffic, and confusion" reigned among convoys seeking to cross. In Pyongyang the South Koreans assumed the role of executioner. Throughout the city of broad avenues and shade trees, firing squads were disposing of political prisoners. Dovell recalled that during the First World War a French veterinarian would hold sick call at an artillery corral every morning by shooting the injured horses. In Pyongyang he remarked to General Walker, who also had served in World War I, "The Veterinarian is holding sick call again."¹⁹

Housed in a former teachers college at the end of an airstrip, the 8055th MASH had its most comfortable building up to that time. Business picked up as casualties from an airborne drop to the north began to arrive by helicopter and L-5. The weather cooled noticeably, frost appeared at night, and the aircraft thundered overhead to the airstrip twenty-four hours a day. Medics evacuated the most serious cases to Japan by air, the less serious also by air to Kimpo Airfield for treatment at the 4th Field Hospital. Again the lack of functioning railroads and the difficulties of wheeled travel forced a total dependence on aircraft. Despite the continuing losses, the increasing cold, and the somewhat grim surroundings of Pyongyang, amenities appeared. The 2d Division had portable showers; fresh meat and fresh eggs returned to the menu; and the month ended with a feast of steak and ham. Above all, rumors of the impending end of the war were everywhere: "Most of us," wrote a nurse, "hoped that our next journey would be southward." But the Double Nickel had not yet completed its journey to the north.²⁰

Meanwhile, the diversification of the medical system continued. During September a change of organization within the Eighth Army had brought into being two new corps, the I and IX. Corps surgeons initially found themselves to be the fifth wheels of the medical system. Coming belatedly to an organization that had operated since the beginning of the war without a corps level, they found that the medical administrative channels ran direct from the divisions to Army headquarters. The Eighth Army also controlled the hospitals and medical support functions, including helicopter evacuation from the divisions to the MASH. Under the reorganization the corps surgeons screened requests and authorized evacuation. But aside from these functions, their duties apparently were slight. The IX Corps surgeon, for example, spent the majority of his time running a dispensary for his headquarters and, during October, supervising medical service for a prisoner-of-war stockade at Taejon.²¹

¹⁹First quotation from Ltr, Hume to Bliss, 30 Oct 50, RG 338, MMFB. Second quotation from Dovell Interv, 21 Sep 66, p. 13, HRB. Description of Pyongyang in Interv, Samuel Milner with Col Rudolph P. Czaja, MSC, 1 Jul 66, p. 3, AMEDD Oral History file (Czaja), HRB.

²⁰Porter "History," in 8055th MASH Monthly Historical Report, 1-31 Oct 50, RG 407, MMFB.

²¹I and IX Corps, Annual Reports of Medical Service Activities, 1950, pp. 3-4 and pp. 1-2, respectively, files 319-1.2 (I Corps) and (IX Corps) Far East-1950, HRB.

Another medical unit, the 171st Evacuation Hospital, also joined the growing complex at Pyongyang, rather than remaining at Seoul, its planned location. Even more than the usual confusion attended its movement into Korea. Most of its professional complement at one point were dispersed to other units, and its enlisted people and equipment spent twenty days on an "abominable" Japanese cargo ship waiting to berth at Inchon. Arriving on 25 October, the 171st set up shop in a former hospital and medical college once maintained by Russian advisers. Much of the medical supplies captured along with the building were still in good condition, and the X-ray equipment was soon in use again by its new owners. On a visit Hume was amused to find that signs throughout the building were written "in large letters in Russian, in medium-sized letters in Chinese, and in small letters in Korean." By November this building, which had served such varied uses, was receiving heavy casualties from increased fighting in the North.²²

The Advance to the Yalu

The withdrawal of X Corps units from Seoul had presaged a new landing, this time on the east coast, at Wonsan, the objective also of the ROK Army drive. For this movement, the 1st MASH was attached to the 7th Division and, early on 8 October, left Inchon on a motor convoy to link up with the 7th Medical Battalion south of Seoul. Here word arrived that guerillas had ambushed the preceding serial of the convoy, delaying departure for Pusan. About 0300 on the ninth the convoy was attacked. Under fire for eleven hours, the sky "lit up from gunfire and burning vehicles,"²³ the MASH treated infantrymen who were wounded trying to clear the enemy-held area. Until afternoon an impromptu hospital worked at the roadside, giving blood, doing necessary surgery, treating for shock, and putting the wounded into ambulances. At last the roads were cleared, the convoy rolled, and the 1st MASH reached its destination without further incident.

For a few days its medics stayed with the 64th Field Hospital, caring for POWs. On 16 October the 1st MASH boarded the USS *General Edwin D. Patrick* and waited on shipboard for thirteen days of "clean comfortable living" while the invasion plan was revised. The ROK I Corps had captured Wonsan—indeed, General Hume was there on 25 October when arriving U.S. Marines received welcomes from Bob Hope and his theatrical troupe, in town to entertain U.N. forces. ("Just how this will fit in [with] . . . the Halls of Montezuma," Hume wrote the surgeon general, "I cannot say.") The 7th Division now was diverted to Iwon, a coastal town far to the north. From there the division

²²First quotation from 171st Evacuation Hospital, Semimobile, Annual Report of Medical Service Activities, 1950, p. 5, file 319.1-2 (171st Evacuation Hospital, Smb) Far East-1950, HRB. See also *ibid.*, p. 6, HRB. Second quotation from Ltr, Maj Gen Edgar Erskine Hume, Chief Surgeon, FEC, to Maj Gen Raymond W. Bliss, Surgeon General, DA, 13 Nov 50, file 312.3 (Correspondence-SGO-Washington), Box 3106 (Medical Section, FEC, General Records, 1950), RG 338, MMFB.

²³Coleman, "Army Nurses in Korea," 2 May 51, HRB.



CORPSMAN TREATING DAUGHTER OF A NORTH KOREAN OFFICER.
South Korean soldiers had executed the child's mother.

was to strike over “a poor dirt road that twisted its way through the mountains and the Korean upland” to Hyesanjin on the Manchurian border, 70 air miles away.²⁴

After landing, the 1st MASH spent a frigid night near Iwon in an unheated windowless building. Next day it moved on to the larger inland town of Pukchong and opened for business in a schoolhouse. Reunited with its equipment, the unit functioned as the surgical hospital envisioned in the T/O&E—a most unusual condition. Three surgical teams worked steadily, the postoperative section was just as busy, and the holding ward was overfull. Increasingly harsh weather and enemy activity both contributed to rising casualties. In Korea as a whole, the daily average of 40 per day during October rose to 326 in November, with worse to come. The vile roads slowed evacuation from the MASH to the major northern city of Hamhung, where the 121st Evacuation Hospital, after similar travels, had set up near X Corps headquarters. Here almost three thousand patients were admitted between 5 November and 10 December.²⁵

²⁴First quotation from *ibid.* Second quotation from Ltr, Hume to Bliss, 30 Oct 50, RG 338, MMFB. Third quotation from Appleman, *South to the Naktong*, p. 732. See also 1st MASH, Annual Report of Medical Service Activities, 1950, p. 1, HRB.

²⁵Coleman, “Army Nurses in Korea,” 2 May 51, HRB; 121st Evacuation Hospital, Annual Report of Medical Service Activities, 1950, p. 4, HRB.

Of growing concern was the question of Chinese intervention in the war. On 25 October strong assaults hit the South Korean forces advancing on the right of the Eighth Army. Others struck the X Corps. Then the new combatants withdrew behind a screen of North Korean forces, for the moment biding their time. In the first week of November tactical units probed toward the Manchurian border, engaged the Chinese, and sent back prisoners from a variety of units to the stockades. Anxiety rose among American officers. Dispersed between the Eighth Army advancing in the west and the X Corps forces moving inland from the east coast, with the central mountains between them, U.N. forces were poorly situated to meet an attack.

"As you may well suppose," wrote Hume on 13 November, "our thoughts just now are chiefly concerned with the part the Chinese Communists are playing and may in the future play in the war. . . . We may find ourselves in a far larger military adventure than has been contemplated thus far." Yet the northward drive continued, now sustained largely by a fading hope that large-scale intervention would not occur. On the morning of the twenty-first men of the 7th Division's 17th Regimental Combat Team entered the battered, frozen town of Hyesanjin. From the bank of the Yalu River they gazed across sheets of ice and a narrow, still running channel of water into the People's Republic of China, a landscape of wintry fields and snow-powdered dun hills.²⁶

The 7th Medical Battalion provided continuous support. When the 17th Regimental Combat Team made its initial assault landing at Iwon, the clearing company and an ambulance platoon had come ashore with them. The bulk of the medical battalion moved inland to Pukchong and set up a clearing station beside the 1st MASH. For a time one clearing platoon provided shore to ship evacuation at Iwon until the start-up of regular runs to the 121st Evacuation Hospital at Hamhung. During the northward drive, another clearing platoon accompanied the 17th, while the one at Iwon moved forward to provide an intermediate station between the Yalu and Pukchong. A tortuous evacuation route took form, running 40 miles from the advanced elements at Hyesanjin to a clearing station in the hamlet of Kapsan; thence another 42 miles to Pungsan; and from there over mountainous and rough terrain 68 miles to Pukchong. Here rail service and ambulances were available for the last 80 miles to the 121st. To cover a relatively brief air distance, the injured had to travel some 230 road miles in temperatures that dropped as low as -24°F.

The route had its dangers. On one occasion an ambulance with five patients lost its way and failed to report at its destination. In savage cold a search party set out under the 7th Medical Battalion commander, Maj. Oren C. Atchley, a Medical Service Corps officer, only to run into an ambush. Atchley became separated from his men and ultimately was listed as missing in action. Led by a sergeant, the survivors started on a long trek through unknown country in an attempt to circle back to their own lines. The cold was the worst enemy now. "The two drivers were in very bad shape," the sergeant reported. "Williams' feet were so bad he couldn't get his shoes on. His feet were swollen and the toe nails

²⁶Quoted words in Ltr, Hume to Bliss, 13 Nov 50, RG 338, MMFB. See also Appleman, *South to the Nakdong*, pp. 736–38.

were dropping off.”²⁷ Captured by North Koreans, the last two members of the ill-fated relief party unexpectedly regained their freedom, rescued by an American patrol, and eventually reached the 121st Evacuation Hospital for treatment. The ambulance and its patients and most of the would-be rescuers had vanished into the forbidding Korean hinterland.

A unit new to Korea, the 3d Infantry Division, also sustained losses. Between 12 and 17 November divisional elements arrived in Wonsan to strengthen the invasion of the North. The division had formed its regiments—7th, 15th, and 65th Infantry—into regimental combat teams, each supported by its regimental medical company plus an ambulance and a clearing platoon from the 3d Medical Battalion. As the division moved inland, evacuation routes became tortuous and long, about 70 miles from the aid stations to Wonsan where two Navy hospital ships lay offshore. Because guerillas were active, armed truck convoys became essential; yet such a convoy might only draw the guerillas’ attention. Near Majon-ni, a town about 20 miles southwest of Wonsan, two convoys of the 15th Regimental Combat Team were ambushed on 27 and 29 November. Ambulances were in the columns, and four were destroyed. Two medics were wounded in the action, and four were reported missing.²⁸

Meanwhile, in western Korea, the advance of the Eighth Army also had carried medical units into the northernmost regions. In a drive to the Chongchon River, troops of the 187th Airborne Regimental Combat Team dropped north of Pyongyang near Sukchon and Sunchon, hoping to cut off fleeing North Koreans and rescue American POWs. The airborne troops were accompanied by unit medics, one of whom, Pfc. Richard G. Wilson, a company aidman, gave his life in night fighting, as he struggled to reach and care for the wounded. For this he was awarded the nation’s highest military decoration, the Medal of Honor.

On 24 October Eighth Army crossed the Chongchon, at a latitude roughly equal to that of Hamhung. With it moved the 8063d MASH. On 3 November the hospital left Pyongyang for Anju, near the Chongchon, and during the days that followed occupied a number of sites—at Sukchon, Sinanju, and Anju again—before the end of November. For a time at the end of the month the 8076th MASH operated in Kunu-ri, a few miles from the river’s southern bank. On the twenty-eighth a section of the 8055th MASH reached Sunchon, only to be ordered back again. During field operations in these northern areas, medics learned only too well that not one but two new enemies were in the field. The Korean winter had closed down, filling the hospitals with men who had been disabled as effectively by the cold as by enemy weapons.²⁹

²⁷DF, Commander, 7th Medical Battalion, to Surgeon, 7th Infantry Division, 28 Nov 50, sub: MIA Report on Battalion Commander, 7th Medical Battalion, Encl 1 to 7th Medical Battalion Command Report, December 1950, file 307-MED (Command Report, 7th Medical Bn, 7th Inf Div, Dec 50), Box 3185 (7th Inf Div, 307-MED to 307-TK, 1950), Entry 429, RG 407, MMFB.

²⁸3d Infantry Division and 3d Medical Battalion, Annual Reports of Medical Service Activities, 1950, pp. 1-2 and p. 3, respectively, files 319.1-2 (3d Inf Div) and (3d Medical Bn) Far East-1950, HRB.

²⁹Appleman, *South to the Naktong*, pp. 655-59; MASH chronologies in 8086th Army Unit, “Surgical Hospital in Korea,” RG 319, MMHB; 64th Field Hospital, Annual Report of Medical Service Activities, 1950, p. 9, file 319.1-2 (64th Field Hospital) Far East-1950, HRB; U.S. Con-

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The Forces of General Winter

"The weather . . . is now bitterly cold," wrote General Hume from Pyongyang in mid-November. "Even when wearing all of the winter clothing that we possessed, it was uncomfortable." Icy winds stripped the heat from the body. In remote mountainous areas, where troops were fighting near the reservoirs that supplied North Korea's electric power, conditions were worst. In the 7th Division 142 men were treated for frostbite, and 83 of these were from the 31st Infantry, operating near the Pujon Reservoir. In the Changjin (Chosin) Reservoir area, the temperature dropped forty degrees over the night of 10–11 November, from 32° to -8°F. More than 200 marines had to be hospitalized by Navy medics. Water-soluble medicines froze; plasma had to be warmed for an hour or more to be usable. The Eighth Army also suffered. On the thirteenth extremely cold weather struck the 2d Division. Here, too, aid stations complained that plasma was freezing, and Dovell himself suffered frostbitten feet while visiting the division.³⁰

The paradox of the situation was that the Far East Command had anticipated the problem and made preparations to meet it. Senior officers of the Medical Service knew the losses suffered during the winter of 1944–45 in Europe—some forty-six thousand casualties requiring an average hospitalization of fifty days, almost all of them front-line riflemen who could ill be spared. During World War II as a whole, over ninety thousand hospital admissions had occurred from injuries associated with cold, including frostbite, trenchfoot, and immersion foot. The severity of the Korean winter was also well known, from the American occupation there. Consequently, the Far East Command during the summer assigned one quartermaster officer and one enlisted man to each division of the Eighth Army to educate supply officers, line officers, and troops in preventing cold injuries. Every soldier underwent a two-hour period of instruction on the subject. Working closely with the quartermaster, the command's Medical Section developed a program that emphasized not only adequate winter clothing and equipment, which units had started to receive, but also command action and continuous education of the troops. Two results of the program were the printing and distributing of a pamphlet called "Cold Facts for Keeping Warm" and, on 22 September, the issuing of a command letter on preventive measures.

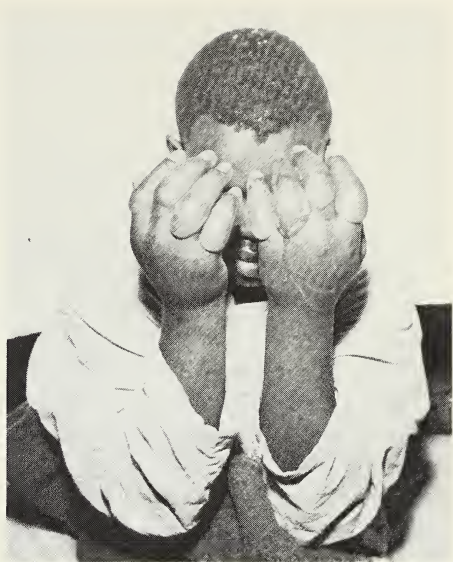
Yet many men succumbed to the fierceness of General Winter's first attack in November. In the rapid advance some units outran their suppliers and failed to receive a full issue. In early November, nurses in the 1st MASH at Pukchong were "wearing the same winter issue that the men do," with "two or three pairs of socks" to fill the empty space in the smallest soldier's boot, which was size

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gress, Senate, Committee on Veterans' Affairs, *Medal of Honor Recipients, 1963–1973*, 93d Cong., 1st sess., 22 October 1973, Committee Print no. 15 (Washington, D.C.: Government Printing Office, 1973), p. 804.

³⁰Quoted words from Ltr, Hume to Bliss, 13 Nov 50, RG 338, MMFB. See also 2d Infantry Division, Annual Report of Medical Service Activities, 1950, p. 4, HRB; Appleman, *South to the Naktong*, pp. 738, 744.

eight. Though efforts continued to fully equip the troops, numerous injuries appeared with the mid-November cold wave, shot upward in the week of 24 November–1 December, and reached a peak of 293 admissions in the week of 29 December–5 January 1951. During 1950 a total of 1,791 cases were recorded, an incidence of 34 per 1,000 troops per annum. The 121st Evacuation Hospital alone recorded 850 cases between 12 November and 24 December and termed cold injury “our most outstanding clinical experience.” As a result, the Far East Command on 29 November opened a cold injury treatment center at Osaka Army Hospital. But the early months of 1951 would see the problem become still more severe.³¹



THE EFFECTS OF FROSTBITE

Over the months that followed, research at Osaka and in the United States developed a picture of cold injury that revealed it to be far more than a matter of frozen toes. Involved in its incidence were factors of environment and heredity, military sociology, and battlefield realities. Basic of course was the climate of Korea, with its harsh Siberian winters and drastic temperature changes. Race was a factor. Black soldiers suffered more than whites, even in integrated units where differences in motivation, training, and discipline were at a minimum. Lower ranks (especially privates and privates first class) suffered far beyond their proportional numbers; line units, for evident reasons, more than support troops. For whatever cause, younger soldiers appeared to be more susceptible than men over twenty-five, perhaps because of a lack of personal discipline. Soldiers from warm states apparently were more subject to injury than those from cold states. Surprisingly, no clear data emerged to justify the logical assumptions that veterans were less susceptible than replacements, and non-smokers—because tobacco causes constriction of peripheral blood vessels—than smokers.

A typical case was that of a seventeen-year-old black soldier who suffered frostbitten feet when pinned down for twelve hours at 0°F. When he finally was able to remove his boots, his feet swelled to such an extent that he was unable to replace them. Evacuated, he went through a lengthy period of hospitalization during which his toes became mummified. Forty-three days after the initial injury, eight toes were amputated. Final closure and grafting were performed in a zone-of-interior hospital ninety-nine days after his frigid hours under fire. As

³¹First quotation from Coleman, “Army Nurses in Korea,” 2 May 51. Second quotation from 121st Evacuation Hospital, Annual Report of Medical Service Activities, 1950, p. 9. Both in HRB. See also FEC, Annual Report of Medical Service Activities, 1950, pp. 69–71, HRB. Besides Army casualties, the Marine Corps sustained 400–500 cold injury losses as well.

this case indicated, a prime problem with cold injury was not only the number of men it disabled but also the lengthy treatment they often required.³²

Cold injury struck both armies. The common American notion that Asian peasant soldiers were used to the winters of their homeland had some validity, yet General Winter took his toll among them as well. In one group of 227 Chinese prisoners taken by the 1st Marine Division, for example, 90 percent was reported to have varying degrees of frostbite. This did not indicate a similar toll on the entire Chinese Army, for frostbite, by disabling the victim, was a common cause of capture. Nevertheless, the enemy clearly possessed no immunity, and lacked adequate clothing and facilities. (POWs reported that there was no evacuation for cold injury cases.) "When the fighters bivouac in snow-covered ground their feet, socks and hands freeze together in one ice-ball," declared a Chinese officer in early 1951, and an American medic during the winter fighting viewed with pity enemy corpses dressed only in quilted cotton and the equivalent of tennis shoes.³³

From the viewpoint of U.N. forces, however, General Winter made common cause with the invaders. Men pinned down in the snow or isolated by enveloping attacks were in no position to prevent frostbite by any available means. Peaks in cold injury coincided with peaks in enemy activity, winter's ice conspiring with hostile fire.

The unavoidable factors of weather, heredity, and war, however, were not the whole story. Conceding the realities of the situation, the Far East Command admitted that many injuries were "without question . . . preventable." A basic problem was the prescribed item of footwear—the shoepac, a winterized boot worn over heavy socks and felt insoles. Many complaints had surfaced during World War II about this piece of equipment. Indeed, a form of injury carried its name. "Among those who wore it," wrote two Army surgeons, "a cycle was often set up of perspiration, maceration, and the development of so-called shoepac foot," followed by "hospitalization for 10 to 15 days, return to duty, and a repetition of the cycle." To avoid injury, troops in Korea, like those in World War II, were urged to remove the boot frequently and dry the socks and insole. Unfortunately, this was not very realistic under battlefield conditions. "Were there nothing else for troops to do but protect themselves from the cold," reported the command's Medical Section with some irony, "protection might be afforded [by the shoepac]. . . . However, the present equipment, particularly the footgear, will not provide the needed protection during active combat under the cold conditions which have been experienced in Korea."³⁴

³²Kenneth D. Orr and D. C. Fainer, "Cold Injuries in Korea During the Winter of 1950–51," pp. 1–18, 32–33, Professional Papers, Box 52, Series 2, Medical Historical Unit Collection, Archives, U.S. Army Military History Institute, Carlisle, Penn. Later studies confirmed the genetic susceptibility of blacks. See Kenneth D. Orr et al., *Cold Injury—Korea, 1951–52*, Report no. 113 (Fort Knox, Ky.: Army Medical Research Laboratory, 1953), pp. 205–568, especially p. 374.

³³Quoted words as related in Goulden, *Korea*, p. 463. See also Summary Intelligence Report no. 3018, 13/14 Dec 50, in Encl 4, to Weekend Letter no. 13, Hume to Bliss, 2 Jan 51, file 200 (Personnel Letters Between SGO and Medical Section, FEC), Box 3099 (Medical Section, FEC, General Records, 1950), RG 338, MMFB; Narrative Ltr, V. J. Navarre, M.D., to Samuel Milner, 19 Feb 67, p. 28, AMEDD Oral History file (Navarre), HRB.

³⁴First and third quotations from FEC, Annual Report of Medical Service Activities, 1950, pp.

The year ended with cold injury a problem still to be solved. General Winter's assault would have been serious under any conditions. But the course of the war now intervened to make it incomparably worse.

"An Entirely New War"

Though startled by the early Chinese attacks and confused by the enemy's subsequent withdrawal, the Eighth Army resumed its advance through western North Korea in late November. On the left the I Corps comprised the 24th Division, an ROK division, and the 7th British Commonwealth Brigade. In the center the IX Corps included the 2d and 25th Divisions and a Turkish brigade. To the right the ROK II Corps, hard hit in the attack, was again ready to move. The 1st Cavalry Division remained in reserve. Chinese opposition to the movement was spotty; seemingly random attacks came, interspersed with long-range rifle fire and mortar shells. Casualties remained light through 24 and 25 November. All units gained ground, and General Walker planned a further advance on the twenty-sixth.³⁵

After dark, however, Chinese bugles announced enemy assaults against the units in the Chongchon valley and against the 38th Infantry along the Paengnyong River, a tributary of the Chongchon. In the darkness, confused fighting marked by enemy tactics of infiltration and encirclement spelled the end of the advance. Soon after, the collapse of the ROK sector brought a far graver threat to the U.N. forces. General enemy assaults on the nights of 26 and 27 November increased the pressure. By the end of the month the Eighth Army was in retreat.

Chinese attack columns infiltrated and then disrupted the 2d Division. Along the line of the retreat wounded piled up in roadside ditches, their companions the dead and men yet uninjured who were sheltering from enemy fire. In one such "shattered mass," wrote historian S. L. A. Marshall,

the men who were still partly mobile crawled forward along the chain of bodies toward the upper end of the ditch. As they moved, those who were down and hurt cried: 'Water! Water!' or 'First aid! First aid!' Long since, nearly all canteens had been drained dry. But [M. Sgt. Owen] McGregor witnessed how the able-bodied checked long enough to do what bandaging they could as they made the upward climb; there were some who stripped to the waist in the bitter cold and tore up their undershirts to use them for dressings. . . . In his dark hour McGregor saw more of the decency of men than he had ever expected to find.³⁶

70-71, HRB. Second quotation from Tom F. Whayne and Michael E. DeBakey, *Cold Injury, Ground Type*, Medical Department, United States Army (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1958), p. 158. See also S. L. A. Marshall, *Commentary on Infantry Operations and Weapons Usage in Korea, Winter of 1950-51*, ORO-R-13 (Chevy Chase, Md.: Operations Research Office, Johns Hopkins University, 1951), pp. 49-50.

³⁵Billy C. Mossman, *Ebb and Flow*, United States Army in the Korean War (Washington, D.C.: U.S. Army Center of Military History, forthcoming), ch. 4. Background on the Chinese attack and the U.N. withdrawal is based upon this source, except as otherwise noted. Quoted words in subhead from Radiogram C 69953, CINCFE to JCS, 28 Nov 50, JCS Outgoing file, Box 43, RG 9 (Collection of Messages, 1945-51), MacArthur Memorial Archives, Norfolk, Va.

³⁶This and the following two paragraphs are from S. L. A. Marshall, *The River and the Gauntlet*:

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In the 38th Infantry the medical support system failed. Stacked several deep in litter jeeps and trailers, the wounded were too many for the available vehicles. "There was no way to keep them warm," said Lt. Paul A. Maxson, the assistant surgeon. "We had no blankets for them . . . The men in the top litters urinated on the men below them." When enemy fire sprayed the convoy, Maxson and Sgt. Robert Gilstrap, himself injured, shared the burden of crawling with a wounded corporal from the medical company on their backs for hundreds of yards. With a shattered left arm and a bullet in his groin, the man became violently ill on Maxson's back, vomiting and defecating on him. Eventually Maxson was able to crowd six wounded men on a jeep sent out to collect casualties. Maxson then walked behind the jeep, leading the ambulatory wounded. By this time he was soaked in blood, none of it his own.

With four drivers, two first-aid men, and a motley collection of ambulances, vans, and deuce-and-a-halves loaded with blankets and bedding, Capt. William O. Burla, an intelligence officer from the 2d Division set out on orders to collect the wounded. Again they were stacked up, rolled in blankets with no medication but a shot of morphine. Most "asked only for water, and of that we were not short," said Burla. When a machine gun blasted away the radiator of an ambulance, a deuce-and-a-half took it in tow. Despite enemy fire, the rough roads, and the cold, only 2 of the 140 men crowded into the vehicles died.

In the eastern mountains soldiers and marines assigned to X Corps were advancing near the Changjin Reservoir (the famous Frozen Chosin, to use its Japanese name) when the enemy struck. On the night of 27 November, as a bitter wind blew off the reservoir, Chinese bugles and whistle blasts guided sharp attacks against Marine positions. Soon the forces near the reservoir had been isolated. Air evacuation proved itself again, as Marine helicopters flew casualties from isolated units to airstrips, where small fixed-wing L-type X Corps planes shuttled them out to medical aid. On return trips the fixed- and rotary-wing aircraft of "Little Lift" brought medicines and supplies to the front.

The Chinese attacked Army troops as well. Typical of many were the adventures of Capt. Vincent J. Navarre, surgeon of the 1st Battalion, 32d Infantry, and of Sfc. D. E. Wagoner, platoon sergeant of the regimental medical company's 1st Platoon that was attached to support the battalion.³⁷ (Wagoner was acting platoon leader for lack of a Medical Service Corps officer.) The men had accompanied a thrust up the east side of the reservoir in clear, increasingly bitter weather. When the attacks began, Navarre argued vigorously with two lightly wounded infantrymen that only a patrol action was involved. Ironically he was winning the dispute when the first wave of serious casualties flooded into his aid station. Among them was a friend, gray-faced and badly hurt. "He

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Defeat of the Eighth Army by the Chinese Communist Forces, November, 1950, in the Battle of the Chongchon River, Korea (New York: Morrow, 1953), pp. 315–17, 324–36. First quotation on p. 301; second quotation on p. 315; third quotation on p. 326.

³⁷This and the following six paragraphs on Navarre and Wagoner's ordeal are based on Narrative Ltr, Navarre to Milner, 19 Feb 66, HRB; Narrative Ltr, Maj. D. E. Wagoner, MSC, to Samuel Milner, 5 Oct 66, AMEDD Oral History file (Wagoner), HRB. Quotations, as they appear in the text, are: Navarre, p. 13; Wagoner, p. 3; Navarre, p. 28; *ibid.*, pp. 35–36; *ibid.*, p. 41; *ibid.*, p. 46; *ibid.*, p. 46; Wagoner, p. 6; *ibid.*, p. 7; *ibid.*, p. 7; Navarre, p. 55; *ibid.*, p. 57.

smelled of powder, his clothes were smeared with mud and snow; and he groaned with pain and muttered about the cold." As the attacks became heavier, the battalion packed up its equipment, loaded its wounded on any available vehicle, and began a nightmare trek back through the mountains, harassed by roadblocks and repeated attacks. There was no way to evacuate the wounded, and the men of the aid station began to learn the burden of nursing care. Bed pans were improvised from cardboard boxes and urinals from C-ration cans. One casualty, feeling the sharp metal edge, told the corpsman, "Watch it, Doc, I only want to urinate, not be circumcized."

Attrition wore down the battalion. Fights were usually at night, fiercely contested. "We were told of the artillerymen firing muzzle bursts from their howitzers, and the two quad-fifty machine gunners, manning those anti-aircraft guns, raking the advancing enemy." But the medics were running low on everything, including bandages. They used T-shirts, or cut the unused sides and ends of bandages from one man to use on another. A mortar round dropped near Navarre. "The force lifted me a few inches, tipped me over, chewed the outside of my right pants leg in a moth-eaten pattern, and wafted the helmet from my head." Marine Corsairs appeared whenever the weather permitted, dropping napalm on the Chinese. One canister fell short, engulfing Americans at the column's front. "I could feel the heat," said Navarre later, remembering that he saw "a man or two black as soot and whirling about with a blue flame issuing from his head like a bunsen burner's."

Then a ricocheting bullet broke Navarre's right knee. Getting him evacuated seemed impossible, for the trucks were "a fantastic sight . . . piled . . . just as full of wounded as could possibly be held." Wounded lay across the fenders and hoods. Finally, an infantry officer took him by the seat of the pants and the back of the coat and threw him into an ambulance, observing, "There's always room for one more." Here in a warm pile of bodies Navarre rode in fair comfort until the driver was killed at a roadblock after dark. He extricated himself and fell outside into shocking -30°F cold. On his elbow and good knee, one hand frostbitten and the other losing sensation even as he sought to flex it, he dragged himself through brilliant moonlight, listening to the Chinese chase the Americans and shoot at them.

Meanwhile, Sergeant Wagoner was having adventures of his own. At a roadblock he encountered the thickly quilted form of a Chinese soldier. Wagoner shot him with his .45 pistol, the first time he had killed a man at close enough range to see his facial expression. "As the powerful round hit him his body jumped a foot or more. His look of stunned surprise amused me and at the same time arouse an overwhelming rage. I happily pumped rounds into his lifeless body until I realized that I was wasting very scarce ammunition."

Later, in the darkness, a mortar round landed on a truckful of wounded men and flung Wagoner to the ground, stunned. He woke under the same brilliant moon. Chinese soldiers walked among the wounded and the dead, probing bodies with their rifle butts. Both kindness and cruelty walked with them. "If there was a response they would offer the casualty a drink from a steaming canteen, if not they searched for watches." Later on another soldier thrust his bayonet into a body. His companions laughed. Crawling away, Wagoner collect-

ed about fifteen wounded who had escaped “the carnage on the road.” Taking a small man on his back, he led the way south until he blundered into a Marine perimeter.

Navarre, broken leg and all, had made it to a Korean village, where he was fed and warmed by a solicitous farmer. He had no way to tell how his host viewed him—as a guest, or perhaps as a commodity for future trade with the winning side. A North Korean soldier wandered into the house and out again; then a South Korean. Eventually a loud-mouthed GI found his way into the same refuge, setting off an episode of gross comedy. “I’ve got to s—t,” he said. Papasan didn’t arrive in time [to show him the latrine] and an accident occurred. Now the poor man began almost to cry, and kept repeating that he had never done that before. I consoled him saying that it could happen to anyone, and the whole scene must have been ludicrous.”

Placed in an oxcart by another GI and a hard-faced peasant woman, Navarre and his unlikely party started south. They met some Marine aidmen in a jeep, and the doctor watched as one of them splinted his broken leg with a carbine. Then came a dimly remembered succession of vehicles—ambulance, light plane, more ambulances, a small boat, a hospital ship riding in the Sea of Japan. Here an officious sailor wanted to know who had tied the carbine to his leg. “Do you know,” he demanded, “that gun was cocked and loaded?”

By the end of November all of X Corps had begun to withdraw toward Hamhung and its port city of Hungnam. Retreating marines counted losses of 20 percent. By 10 December the corps as a whole numbered almost nine thousand killed, wounded, and missing since the Chinese attack had begun thirteen days before. On the following day General Almond published plans for a general evacuation by sea from Hungnam. Whether this would be a complex logistical exercise or a Dunkirk-style departure under fire remained to be seen.³⁸

While the eastern forces withdrew into a defensive perimeter, the retreat in the west continued as well. Though not a rout—units retained their coherence—the Eighth Army was infected with “bug-out fever,” in the phrase of the time, to which there was no medical cure. Unit medics struggled with the problems of the new retreat. Typical was the 2d Medical Battalion. On 29 November the battalion formed a motor convoy and started south toward Sukchon. Eight miles beyond Kunu-ri they ran into a massive Chinese roadblock and were obliged to detour by way of Anju and Sinanju to their destination. After a brief rest they pushed on to Pyongyang. Under the attack casualties soared, which meant that maximum work for all personnel coincided with the retreat. The battalion’s own losses included eight doctors, two dentists, and nine Medical Service Corps officers. Evacuation was by any means available. Helicopters, despite their fragile reputation, proved invaluable, on one occasion removing 29 casualties from an area that was completely cut off by the Chinese. Men isolated by the attack straggled in after walking around the enemy, over mountains and through icy streams. When the division halted to reorganize, its surgeon counted 143 cases of cold injury.³⁹

³⁸Mossman, *Ebb and Flow*, ch. 11.

³⁹2d Infantry Division, Annual Report of Medical Service Activities, 1950, pp. 4–5, HRB.

Behind the fighting units the hospitals were also in retreat, and thus the chain of evacuation shifted from day to day. At Kunu-ri the 8076th MASH no sooner had finished its Thanksgiving dinner than 2d Division casualties began to arrive. Rapidly the hospital was overloaded with hundreds of wounded men. Surgeons and nurses had to cope with them despite below-zero cold. Intravenous solutions froze in liter flasks. Diesel fuel for heating would not flow unless mixed with kerosene. Space heaters burned out under continuous operation, and ice forming in gasoline caused electric generators to fail. Lights in the operating room winked out, leaving surgeons to work by the glow of potbellied stoves and the unsteady beams of hand-held flashlights. Nurses boiled water on the stoves to clean surgical instruments, but ice formed in the water before they were finished washing. Surgeons' hands were so cold they could hardly hold their instruments, much less operate, and the bodies of the wounded steamed as the surgical knives cut them open. This

was the situation on 27 November. The surgeons had worked straight through the day, without a break. It had turned dark at six that evening. The lights went off and the operating lamps went out. But no sooner did the surgeons begin operating by flashlight, when the lamps went on again. They didn't stay on very long. Within 5 minutes they went off again, and the surgeons had to go back to the flashlights. It went on like this for most of the night, with the lights going on and off; the bellies steaming when you opened them up; and with everything cold and threatening to freeze up.⁴⁰

At a division staff meeting the next day, Colonel Van Buskirk learned that "the ROK's and the Turks had given way on the Division's right flank; and the enemy was pouring in around the flank."⁴¹ Loading its wounded in the bitter cold, the 8076th MASH moved south in a vast, creeping traffic jam—the 2d Division in retreat. Avoiding the roadblock, the hospital was able to join the 8063d MASH at Anju, to eat and to drink hot coffee, and to plan the retreat that both must make, further south to Pyongyang.

When the 8076th MASH withdrew, surgical cases evacuated from the clearing stations went instead to the 8063d MASH now at Sinanju. C-47s flying from an airstrip at Anju lifted other wounded to the 171st Evacuation Hospital at Pyongyang. Then on 29 November Dovell ordered the 171st to close. Shifted to Yongdung-po, it was overtaken by the retreat and, in mid-December, evacuated by ship to Japan.⁴²

At the North Korean capital many streams of the river of men and vehicles running toward the south briefly converged. After a leisurely advance during the autumn the 64th Field Hospital found itself in the enemy capital and, on 28 November, took over the building by the airstrip where the 8055th MASH had worked. The following day—the first workday—began quietly, the familiar round of receiving casualties. Then the influx increased beyond all expectations. During that day the hospital expanded its bed strength three times. Cots filled

⁴⁰Van Buskirk Interv, 7 Jul 66, p. 18, AMEDD Oral History file (Van Buskirk), HRB.

⁴¹Ibid., p. 19, HRB.

⁴²This and the following four paragraphs are based on 64th Field Hospital, Annual Report of Medical Service Activities, 1950, HRB. First quotation on p. 10; second quotation on p. 11; third quotation on p. 12.

every available room and corridor. In the first sixteen hours, 278 admissions took place. By the next day "rumors were rife that the Chinese Communists were coming down from the north in full force." The hospital's evacuation policy was cut to seven days. One doctor took up full-time duty at the airstrip to triage incoming patients. A three-story building nearby became an annex for ambulatory patients. Meanwhile, visits from "Midnight Charlie," a light plane that flew over in the darkness dropping bombs in an attempt to hit the airstrip, enlivened the evenings.

On the afternoon of the thirtieth, patients from retreating medical units poured into the hospital from every conceivable kind of vehicle. Trucks halted long enough to discharge a few wounded, then moved on. Bumper-to-bumper convoys filled the roads, all headed south. In the meantime, evacuation from the hospital went at a feverish pace, using a newly opened railroad line to Seoul as well as the air. Surgeons of the 8063d MASH joined the 64th Field Hospital surgeons in a 24-hour round of continuous operations, stealing an occasional catnap when overcome by exhaustion. On Friday, 1 December, the nurses left by plane for Ascom City, in line with General Walker's orders that they were not to be allowed to fall into the hands of the enemy. At Pyongyang the scenes were as before. "All roads were jammed with vehicles, pieces of equipment, wagons, and anything [else] that had wheels. Many of these same vehicles dropped out of convoy to carry patients to our hospital. The liaison officer at the airport promised that he would obtain airplanes as long as we had patients for evacuation."

Late at night the 64th Field Hospital was ordered to move south the following day, for the 8055th MASH was returning to occupy its old building. Any remaining niceties now went by the board as patients were prepared for mass evacuation. In a large auditorium doctors hastily examined casualties and sent to the evacuation area any whose condition would require more than three days of treatment. Interrupted once by Midnight Charlie, the process continued until 0430 on 2 December. Half an hour after the last patient was tagged for air evacuation, the 64th Field Hospital closed. The 8055th MASH was already in place and working over the nontransportables.

The final days passed "like the pages of a nightmare." The enlisted men and two officers were to accompany the 64th Field Hospital's supplies, loaded into fourteen boxcars on a spur beside the airstrip. The rest of the officers were to share two coaches with a quartermaster detachment. But a party of Turkish soldiers seized one of the coaches, and the other, hooked to their troop train, started south very slowly. The supply train was left behind. Beside the railroad track the airport buildings were burning now, and demolition squads set off intermittent blasts. Late in the afternoon an engine appeared and pulled the half-frozen men and their equipment out of the marshaling yards. After a seemingly interminable journey the hospital's two parts reached Ascom City on 6 and 7 December, respectively. For a week they thawed out and enjoyed the hospitality of the 4th Field Hospital. On the fourteenth the 64th Field Hospital went aboard a troopship in Inchon Harbor; thirty-six hours later, the outfit was on its way to Japan.



HOSPITAL TRAIN EVACUATION FROM PYONGYANG

The MASHs added more steps to their already lengthy itineraries. On 4 December the 8055th closed at Pyongyang and, after eight days at Seoul, moved on to Ascom City. Here solid buildings, steam heat, and the opportunity to plunder the supplies of the 4th Field Hospital brought joy to Colonel Tender and his hard-bitten crew. Also on the fourth the 8063d escaped Pyongyang, one day before the Eighth Army abandoned the burning city. Until the end of the year it, too, enjoyed Ascom City, while the 8076th set up at Suwon, south of Seoul.⁴³

As Eighth Army units fell back below the 38th Parallel, the phased evacuation of the Hamhung-Hungnam perimeter began. Battered in the hills, U.N. forces, once within the perimeter, were little disturbed by light enemy attacks. The X Corps moved out by the numbers to waiting vessels. Typical was the experience of 3d Division medics. Successive withdrawals to previously prepared lines keyed their evacuation; the division's mission was to cover the withdrawal of the other units, then make its own. As it had done both in the advance and in retreat, the 3d Medical Battalion leapfrogged its clearing sta-

⁴³MASH chronologies in 8086th Army Unit, "Surgical Hospital in Korea," RG 319, MMHB. On 27 November 1950 the 8076th MASH was formally redesignated Mobile Army Surgical Hospital, 8076th Army Unit. The other MASHs received similar designations. No notice of this insubstantial change will be taken in the text. See Eighth United States Army, Korea, General Order no. 210, 27 Nov 50, MMFB.

tions. On 22 December the third clearing platoon set up its last position in Hungnam, with orders to close four hours before its scheduled departure; the third ambulance platoon waited to carry its personnel and supplies. Meanwhile, the regimental medical companies set up beach evacuation stations for their outfits. When the clearing company had departed, the remaining aid stations evacuated with their tactical units during the final withdrawal, to carry any last casualties that might occur. Offshore, two Navy hospital ships received the injured, including the victims of a prematurely exploded demolition charge in the dock area.⁴⁴

By this time, the other X Corps unit already had boarded ships. Withdrawn by motor convoy from northeastern Korea on 2 December, the 7th Medical Battalion at Hamhung cared for Marine survivors of the Changjin Reservoir fighting. A clearing platoon and the 1st MASH lingered to support division units still in the hills, but arrived at Hamhung on 5 December. On the fourteenth both boarded the USNS *General H. B. Freeman*; a clearing station that had remained behind left five days later, when relieved by 3d Division medics. After providing temporary quarters for many colleagues from other units, members of the 121st Evacuation Hospital moved on the eleventh to the USNS *Fred C. Ainsworth*. Here they resumed work, performing 163 operations in the hospital ship's facilities.⁴⁵

The 1st MASH bunked in with the 121st Evacuation Hospital for two days before moving to Hungnam beach, where it opened its own hospital in a school. On the evening of 15 December the patients were moved out to the waiting hospital ships. That same night the nurses moved to the USNS *Ainsworth*, while the doctors and enlisted men stayed on shore to pack their gear and see it properly shipped. Four days later they in turn boarded the *Towanda Victory*.

From shipboard the nurses watched the demolitions proceeding in Hungnam. Fires started by naval artillery burned in the surrounding hills. At night the warships were "blasting and shooting flares as though it were a Fourth of July celebration." Near the USNS *Ainsworth* lay the battleship *Missouri*, whose big guns jarred her smaller neighbor at every firing. Air Force planes busied themselves over the shrinking perimeter during daylight hours, and small boats made endless runs to the hospital ships with patients and new evacuees. Colonel Gorby, the X Corps surgeon, visited the ship and told the nurses that they would not, as they had expected, be rejoining the men of the 1st MASH for the voyage, because the old *Towanda* had no accommodations for them except in the brig. Luxuriating in what seemed "a stateside hotel" compared to what they had been accustomed to, the women bathed, washed their hair, and rejoiced at being able to eat "food from a table again."⁴⁶

At 1415 on Christmas Eve, Hungnam shuddered under the blast as the ammunition dump blew up. In less than an hour the whole fleet was moving, carrying the men of X Corps, their wounded, their hospitals and nurses, and

⁴⁴3d Infantry Division, Annual Report of Medical Service Activities, 1950, pp. 1-2, HRB.

⁴⁵7th Medical Battalion and 121st Evacuation Hospital, Annual Reports of Medical Service Activities, 1950, p. 5 and p. 2, respectively, HRB.

⁴⁶Coleman, "Army Nurses in Korea," 2 May 51, HRB.

scores of thousands of Korean refugees fleeing the Chinese advance. From the deck the members of the 121st Evacuation Hospital and their guests watched the burning city until it disappeared from view. Then they settled down to celebrate the holiday. "The ship had Christmas for everyone"—a tree, Santa Claus, and words of cheer for the four hundred patients. The medics ended the evening with a dance in the operating room. The convoy sailed on toward its destination, Pusan. The expedition to the North was over.⁴⁷

The New Shape of Army Medicine

For those who served in Korea, the last six months of 1950 packed in more critical events, more extraordinary changes of fortune, than years of normal life. Members of the Medical Service underwent a radically compressed and intensive learning experience. Though many initial problems were overcome, the formative period left durable marks upon the conflict. The importance of the Japanese hospitals, the heavy emphasis on transport to compensate for lack of personnel and bed space in Korea, and the burgeoning role of the helicopter remained to shape the future.

All things considered, the health of U.N. troops was good. The Medical Service reported a normal rise in upper respiratory infections with the onset of cold weather. Dysentery and hepatitis continued to be serious causes of disability. But the cold that brought frostbite and influenza suppressed many other diseases, such as malaria. Overall, the war of movement that characterized the fighting of 1950 probably prevented or retarded the spread of illness; armies had small chance to pollute their surroundings or spread disease by huddling together in bunkers. On the other hand, preventive medicine was almost impossible, at least in the sense of area control, and cold injury was directly linked to a type of warfare in which the front-line soldier often had no means at all of getting warm or changing his shoes and socks. No illness caused a medical emergency in the autumn and winter fighting, for which, as usual, a mixture of medical discipline, quick evacuation, and luck must be credited.⁴⁸

Medical supply often was catch-as-catch-can during the advance. One consistent problem was providing for the exchange of blankets and litters. Forward hospitals, especially in the X Corps, reported other serious shortages. The 121st Evacuation Hospital found difficulty in getting antibiotics, and the 1st MASH termed the blood supply "sporadic and inconstant." Travel on the rough Korean roads caused the red cells to break apart, and the blood became useless. Either helicopter supply had not yet been widely adopted or the lack of machines prevented its employment. Despite such difficulties, medical supply apparently was not a fundamental problem.⁴⁹

⁴⁷Ibid.

⁴⁸FEC, Reports of ETMD, October 1950, pp. 7–8, and November 1950, p. 5, file 350.05 (FEC) 1950, HRB.

⁴⁹As a primary function of the rear areas, supply is treated at length in Chapter 5 of this volume. Sources of the above paragraph include the 121st Evacuation Hospital and 1st MASH, Annual Reports of Medical Service Activities, 1950, p. 11 and p. 10, respectively, HRB.

Surprisingly few difficulties resulted from the presence of soldiers of many nationalities in the hospitals. Languages differed, but wounds and illness were universals. Quartermasters labored to supply the varied diets demanded by men of different countries. Some Ethiopian soldiers, according to Dovell, insisted that the attending doctor taste the prescribed medication before they would swallow it themselves. "Of course," he remarked, the doctor "couldn't keep that up all day long." But the sick and injured were not, by and large, in any condition to pursue unreasonable demands, even if they were so inclined. The U.N. system handled many kinds of casualties with a minimum of fuss and with great clinical success.⁵⁰

Clear improvements appeared in the psychiatric service. After reaching a peak of 249.7 NPs per 1,000 troops during August, rates dropped rapidly after the breakout from the Pusan Perimeter and fell during the triumphal month of October to 18.4 per 1,000, only to rise again with the onset of cold weather, the Chinese attack, and the beginning of a new retreat. At first extremely limited, the number of psychiatrists in the Far East Command increased steadily. By the end of August, the command had assigned psychiatrists to the 1st Cavalry and 2d, 24th, and 25th Infantry Divisions. However, most of the men who served in Korea during the first year, especially in forward posts, were young, possessed limited professional experience, and had no background in war. As a consequence, they became part of the psychiatric problem as well as a key to its solution. "Initially and in rear assignments," wrote the energetic FEC consultant Col. Albert J. Glass, "the psychiatrist new to combat problems is quite impressed by the manifestations displayed by psychiatric casualties. He is prone to over-identify with the patients. . . . He, also, feels guilty when making recommendation for a more hazardous duty than he fortunately must endure."⁵¹

The solution for the psychiatrist was to move forward, sharing the dangers of the troops to some degree, and gaining their respect while losing his own diffidence. A policy of bringing some basic counseling even to the aid stations significantly improved the rate of men returned to duty. Small psychiatric teams worked at the evacuation and field hospitals, where they provided first- or second-echelon treatment. As a result, the number of psychiatric evacuees to Japan markedly decreased. In pressing for these changes Glass, much to his surprise, found that most line officers were sympathetic and that some division surgeons were not. The effectiveness of psychiatric help in cutting personnel losses at small cost was a constant source of support for his reforms.⁵²

Typically, in the 4th Field Hospital Capt. Harold Kolansky practiced brisk field psychiatry. "Patients were seldom held for more than four days,"⁵³ he

⁵⁰Dovell Interv, 15 Jun 62, tape 2, Personal Interviews file (Dovell), HRB.

⁵¹Quoted words from Glass, "History and Organization of a Theater Psychiatric Service Before and After 30 June 1951," in *Recent Advances in Medicine and Surgery*, 2:365-66. Except as noted, the following section is based on this essay. See also copy of Technical Liaison Office, OSG, "Fact Sheet: Three Years of Medical Service in Korea," 14 Jul 53, HSF (TIO Fact Sheet-1953); FEC and 121st Evacuation Hospital, Annual Reports of Medical Service Activities, 1950, pp. 26-34 and pp. 7-8, respectively. All in HRB.

⁵²FEC, Annual Report of Medical Service Activities, 1950, pp. 26-34, HRB.

⁵³Ibid., p. 29, HRB.

reported. Brief psychotherapy followed the relief of physical exhaustion by rest and food. Sedation was given only when indicated. The basic rule of combat psychiatry—hold the patient as close as possible to the front—proved, however, to have some interesting exceptions. During the fierce fighting that accompanied the recapture of Seoul, the Marine Corps suffered heavy psychiatric as well as physical casualties. NPs airlifted to a Navy hospital ship standing just offshore at Inchon were very difficult to treat, for they felt they had escaped from the combat zone into the relative luxury of the ship. On the other hand, patients evacuated 100 to 150 miles behind the fighting line in Korea showed no adverse effects and responded well to treatment, for they perceived the whole devastated nation as an extension of the front. In short, “distance” was psychological, not a matter of miles.

By the end of 1950 field psychiatry evidently had reached a level of performance at least equal to that of World War II. Even evacuation hospitals, traditionally the least successful facility for treating such problems, had found ways to improve their performance. After difficulties at Ascom City the 121st Evacuation Hospital claimed much better results at Hamhung by setting up two separate wards to treat the large influx of patients produced by the Chinese invasion.

Surgeons, too, were learning better how to work in battlefield conditions, though performance in the Korean hospitals was still marked by some errors in debridement—the surgical removal of dead and dying tissue from a wound. In most major aspects of surgery, however, the Far East Command noted improved performance. “Wounds were never sutured,” typically reported the 121st Evacuation Hospital of its own clinical practice. When patients with sutured wounds arrived from other hospitals, the stitches were promptly removed and, where necessary, further debridement carried out. Cleaning and draining wounds, administering a broad range of antibiotics, and employing helicopter evacuation of the seriously wounded were keys to preventing infection and reducing mortality rates. As for the physical conditions endured by surgeons in the field, little could be done. Since entering Korea, surgeons had worked in weather so hot that rubber gloves filled with sweat and in weather so cold that plasma froze. Surgical cases, unlike most forms of illness, came in spurts, “intense periods of around the clock work corresponding to admission of large numbers of wounded at critical times.” Coffee and catnaps provided the only relief for surgeons and nurses at the few and usually understaffed hospitals. The lack of certain kinds of specialists, notably neurosurgeons, continued unabated. At one point the FEC consultant, on a visit to the 121st Evacuation Hospital, was obliged to pitch in and perform twenty-four operations himself.⁵⁴

The treatment of shock became highly sophisticated. The 121st Evacuation Hospital had a special shock section where victims were aided with “prompt use of whole blood, oxygen, airway aspiration, proper position, external heat, and indicated narcotics.” Whole blood, administered usually through the veins but in “desperate cases” through the arteries, remained the most important weapon against shock. Plasma, markedly less effective, was used only to initiate treatment before the blood arrived. Medics routinely matched blood groups before

⁵⁴121st Evacuation Hospital, Annual Report of Medical Service Activities, 1950, p. 5, HRB.

giving a transfusion, but in the most urgent cases they administered unmatched Type O (universal donor). When doctors suspected a concealed hemorrhage, they performed surgery at once as a resuscitative measure, rather than following the traditional practice of attempting to revive and stabilize the patient first as a prerequisite to an operation. Methods were brusque, but the results were remarkable: The 121st claimed a death rate of only 0.2 percent among its patients. By adding radio-dispatched helicopters to the shock trauma units they had inherited from earlier wars, the hospitals—working under the brutal necessities of the Korean fighting—devised an integrated system of emergency treatment that would not enter civilian medicine for more than a decade to come.⁵⁵

Much of the medical system's success was due to young men, often residents incompletely trained in their specialties. "I would watch these fellows work," Colonel Dovell recalled, "and . . . they did magnificently, they did beautifully. And they would work on shifts, untiring." Next in importance were surely the nurses, to whom Dovell also gave unstinted praise:

I've seen those nurses giving anesthetics, and scrub nurses that would work there [in the operating rooms] until they were practically gone. Somebody would hold up a cup of coffee [to them]. . . . And of course they had a bath last week sometime, I suppose when they got down to a branch of a stream. . . . My hat's off to the people who did a job. I never heard a woman that was a nurse complain as to the roughness and the hardships or anything of the kind.⁵⁶

Dovell himself was an important part of the medical system in Korea. Enjoying a special relationship with General Walker, to whom he owed his appointment as Eighth Army surgeon, Dovell exerted powers far beyond those of an ordinary staff officer. On occasion he moved Eighth Army medical units like chess pieces—for example, detaching the 8063d MASH from the 1st Cavalry Division "on his own authority" and ordering it to Pusan at the end of July. Increasing his power was his ubiquity. Despite his bulk—Maj. Gen. Hobart R. Gay, the division commander, referred to Dovell as "that fat S.O.B." in his absence, and some of his subordinates called him "Buddha"—the Eighth Army surgeon was a man on the move. To his subordinates this was a mixed blessing. He was there when they needed him; he was also there when they felt they did not. Some, like Tender of the 8055th MASH, could do no wrong in Dovell's eyes, while others, like Van Buskirk of the 8076th MASH, found him a hard master. Van Buskirk

knew that Dovell was personally very fond of him and heard that, when he himself wasn't there, [Dovell] was boasting about his accomplishments to others and [would] take pride in how well he was doing. But when the two were together, Dovell would bully [Van] Buskirk unmercifully, and try to make it appear that he could do nothing right.⁵⁷

⁵⁵Ibid., Encl 1, p. 2, HRB.

⁵⁶Dovell Interv, 15 Jun 62, tape 2, HRB.

⁵⁷First quotation from Neuman Interv, 28 May 66, p. 5. Second quotation from Interv, Samuel Milner with Col Wayne S. Hume, MC (hereinafter cited as Hume Interv), 19 May 66, p. 19. Third quotation from Gans Interv, 29 May 66, p. 18. All in AMEDD Oral History files (Neuman), (Hume), (Gans), HRB. Fourth quotation from Van Buskirk Interv, 7 Jul 66, p. 9, HRB.

Dovell relished the grueling pace, despite his sixty years, though it brought him painful and embarrassing moments, as, for example, when he suffered cold injury at the front. Despite fatigue and frostbite, he was a formidable and unforgettable figure, ordering people and units about in his soft Virginia drawl, indulging in barbed ridicule of General Hume, smoking Webster Fancy-Tail cigars, and drinking his favorite Ballantine Scotch. He kept .50-caliber machine guns on his jeep, and a carbine firing tracer bullets ready at hand, and when close enough to the line would stand up and blaze away, in plain sight of everyone, including the enemy.⁵⁸

The personnel shortages demanded some such figure, invested with authority and able to shift men and units where they were needed most. "We lacked doctors, we lacked nurses, we lacked qualified people like anesthetists," said Dovell of his Korean experience, and the lacks helped to define his own role. Though his acerbic personality and feuds with higher-ranking officers prevented him from winning the star he coveted, he became one of the best known officers in Korea, especially among the medics. As a Medical Service Corps officer said, he could hardly have avoided knowing Colonel Dovell: "Almost every time we turned around, Dovell was there."⁵⁹

By year's end the regimental medical companies, the medical battalions, the MASHs, and the field, evacuation and station hospitals had matured into veteran units, able to move and work under the most varied and trying conditions. A composite picture might portray a young surgeon using Japanese sutures to sew up a casualty lying on a World War II operating table in a schoolhouse beside a helicopter landing pad; nurses in bulky men's winter clothing assisting him; an array of antibiotics—not only penicillin but also streptomycin, aureomycin, and chloromycetin—standing in a medical chest or cabinet; blood dripping into the soldier's veins and more warming for transfusion; everyone very tired; and, outside, trucks gunning motors, preparing a move to a new station.

Such an image drawn from the operating room could not, of course, show the real complexity of the medical system, with its administrators, ambulance drivers, hospital train companies, litterbearers, and clearing station personnel. In six months of battle, this array of men and women, mustering the most varied skills, had learned not only how to do their jobs but, more important, how to do their jobs together. Now they needed every gain in experience and knowledge, for they faced a new war against a new enemy.

⁵⁸Gans Interv, 29 May 66, p. 18; Dovell Interv, 21 Sep 66, pp. 18–19. Both in HRB.

⁵⁹Dovell Interv, 15 Jun 62, tape 2, HRB; Mosebar Interv, 30 May 66, p. 12, AMEDD Oral History file (Mosebar), HRB.

CHAPTER 5

Behind the Lines

While the fighting forces endured the extraordinary changes of fortune of the first six months of war, an increasingly elaborate system of depots, hospitals, and transport facilities developed behind the shifting front. Much of the logistical system was medical. The number of medics and medical units increased, the evacuation pipeline took form, and the supply system stabilized. In Japan after the initial drawdown, hospitals grew in number of personnel and specialists and in the complexity of the medical and surgical procedures they could perform. Yet in both Korea and Japan, hospitals remained too few to handle the massive casualty flow. In consequence, the rapidly growing transport system was often called upon to substitute evacuation for forward treatment.

Meanwhile, the conflict became a limited war with a worldwide cast. Seldom in history have forces so diverse traveled so far to fight in a struggle in which their nations had so little immediate stake. On 24 July 1950 the General Headquarters, United Nations Command, was established under General MacArthur. The addition of Korean soldiers and United Nations (U.N.) units to U.S. divisions reshaped medical responsibilities. The American line of communications served U.N. and South Korean soldiers in American units, and their casualties followed the same evacuation routes as Americans, except that they were not returned to the zone of interior. Army hospitals admitted soldiers speaking a babel of tongues, and U.S. soldiers in turn occasionally received treatment in the hospitals of other nations.¹

Early in July General Walker split the Eighth Army headquarters into two parts, sending an advance section into Korea to conduct operations and keeping the Eighth Army, Rear, at Yokohama. Colonel Dovell went with his commander to Korea, and Dovell's deputy, Col. John A. Worrell of the Medical Corps remained in Japan to oversee the medical facilities there. A none too aggressive man, in Dovell's opinion, he acquiesced in the Eighth Army surgeon's desire that Col. Frederick R. Wunderlich, an experienced dental officer and a crony of Dovell's, exercise actual control. Soon, however, the Far East Command (FEC) realized that the Eighth Army could not carry out both combat and logistical functions, if only because the officers remaining in Japan felt unable to make routine decisions without the approval of higher-ups in Korea.

¹United Nations Command General Order no. 1, 24 Jul 50, MMFB; extract from DF, Assistant Chief of Staff, G-4, UNC, to The Surgeon General, DA, 10 Oct 50, sub: Policy for Integration of Forces Into the United Nations Command, HSF (U.N. Command-1950), HRB.

In late July and early August staff officers at the Far East Command held a round of conferences on the problem, concluding that the Eighth Army would have to be divorced from its logistical responsibilities if its combat mission were to succeed. On 25 August the general headquarters created the Japan Logistical Command (JLCOM) under Maj. Gen. Walter L. Weible. For a short time Colonel Worrell served as the JLCOM surgeon. But Brig. Gen. Silas B. Hays, the surgeon general's foremost expert in medical supply, was already on orders to take over the top medical post in the new command. He reported for duty in September 1950. The personnel of Eighth Army, Rear, were transferred en masse to the command. While the Eighth United States Army, Korea (EUSAK), carried on the fighting, the Japan Logistical Command in effect established a communications zone in the Japanese islands.²

Linked by ship and plane, the station and general hospitals in Japan supported EUSAK not only by providing complex care for evacuees but also, on occasion, by receiving casualties direct from the front-line units and the surgical hospitals. During the Pusan Perimeter fighting, Japan's role resembled England's during the fighting on the Normandy beachheads during World War II. But when defeat overtook the North Koreans, the area behind the U.N. lines expanded and in time acquired its own area commands to handle the duties of supporting the front-line troops.

Sources of Supply

Coming only five years after the end of World War II, the Korean fighting was sustained during 1950 largely with weapons and supplies left over from that conflict. To save the lives of their wounded, the U.N. forces depended on stored medical supplies in Japan, with resupply from similar sources in the United States. When rapid use depleted the stocks of some items, the imitative genius of Japanese manufacturers, drawing upon local cottage industry, provided substitutes of variable quality.

Luckily for the U.N. forces, during a two-year period before the outbreak of the Korean conflict medical supply personnel had devoted a major portion of their time to a roll-up of supplies throughout the Far East Command. Everything that could be packaged and stored was saved, and because the only suitable storage facilities were in Japan, materiel of every type was collected and shipped to the main island of Honshu. A large part of Yokohama Medical Depot was set aside for processing. Workers broke down old standard assemblies and put together new ones from the contents. Maintenance was an endless task. Deterioration caused by the tropical climates of Saipan, Guam, and other places where supplies had been kept since World War II had to be repaired. In early 1950 the depot's warehouse branch consisted of seven buildings with an aggre-

²FEC, Report of ETMD, August 1950, p. 13, file 350.05 (FEC) 1950; EUSAK, Annual Report of Medical Service Activities, 1950, pp. 1-2, file 319.1-2 (EUSAK) Far East-1950. Both in HRB. On Worrell and Wunderlich, see Dovell Interv, 21 Sep 66, p. 7, Personal Interviews file (Dovell), HRB. Hays later became surgeon general (1955).



MAJ. GEN. SILAS B. HAYS
(1952 photograph)

gate storage space of over 200,000 square feet. Here mountains of crates and barrels bound with metal straps were piled on skids for movement by forklift.³

With these supplies the U.N. forces met their medical needs during the first months of war. The conflict began suddenly, with no time to requisition from the zone of interior. The depots of the Republic of Korea (ROK) Army were quickly overrun, and the retreat during July brought repeated losses of materiel to the onrushing enemy. From 25 June to 15 September almost no bulk supplies were received from the United States; the war had to be supported from what was on hand until after 1 October, when sizeable quantities began to arrive. As a result, American soldiers in some instances had to learn the value of reduced

expectations, and items that they would have considered substandard and unfit in time of peace proved to be "lifesavers . . . [after] the beginning of the conflict."⁴ Short of all materiel, the ROK Army was glad to get any supplies, and an entire warehouse of obsolescent medical goods, unusable under peacetime standards, was quickly distributed to their fighting forces.

Three other sources supplemented these bulk supplies. The Navy and Air Force made their stocks available to the Army. Certain items that were in short supply in the Far East Command—new antibiotics, smallpox vaccine, and cortisone, among others—were airlifted to Japan from the San Francisco Port of Embarkation. Unlimited funds also were made available to the command to purchase nonstandard medical items in the United States. Though the Yokohama Medical Depot shipped to Korea four times the tonnage of supplies that it received from the zone of interior, the qualitative impact of U.S. imports apparently was great. Quantitatively, goods obtained in Japan itself were more important. Occupation funds bought from the Japanese jerry-built but functional substitutes for items that were not immediately available elsewhere. In consequence, more and more requisitions found their way into the local market place. Tubing and needles from Japanese sources, for example, allowed the 406th Medical General Laboratory to embark on an immediate blood program with local donors.

³FEC, Report of ETMD, October 1950, p. 11, file 350.05 (FEC) 1950; Yokohama Medical Depot, 8061st Army Unit, Annual Report of Medical Service Activities, 1950, Receiving Branch and Maintenance Division secs., file 319.1-2 (Yokohama Medical Depot, 8061st Army Unit) Far East-1950. Both in HRB.

⁴FEC, Report of ETMD, October 1950, p. 11, HRB.

The Army met some problems in such procurement. Quality was compromised, and mass production was nonexistent. Hand labor in scattered independently owned shops turned out the needed goods, and a medical supply officer was later to remember “needles that wouldn’t penetrate the skin; sterilizer gaskets that would blow out at the slightest pressure; sterilizers that simply wouldn’t work; [and] operating tables that would buckle and collapse under the weight of an average American soldier. . . .” Because various agencies bid against each other, prices rose in an inflationary spiral. Aspirin sold for about \$1.50 a bottle in July but rose to almost \$4.00 in November. Yet the Eighth Army surgeon concluded that “all in all the military was able to exploit the local economy to decided advantage.” Field units reported most of the Japanese products to be flimsier than current American standards, more apt to wear out in hard service, but entirely usable during their shorter lifespan.⁵

Getting Supplies to the Troops

The hasty dispatch of critical supplies by air was a feature of the early months of the war. Of the first six planes that left Japan with supplies, two were said to contain medical materiel. Supplies in greater quantity and obtained in more orderly fashion equipped the medical units forming in the Japanese islands. Here a kind of controlled chaos reigned during July and August as new organizations were activated and shipped out on extremely short notice. Fortunately, equipment had been pre-stocked at Yokohama in unit assemblies, one assembly for a MASH, another for a field hospital, and so forth. Unpredictable demands continued to come in from the field, however. At one point virtually the entire medical equipment of the 24th Infantry Division had to be replaced. As supply personnel responded to such demands, wild fluctuations in inventories resulted. “A stock that was adequate on one day,” reported the Eighth Army surgeon, “would become critical with the passing of the next 24 hours.”⁶ In Korea, problems developed in the early days because supplies were shipped pre-packaged in medical maintenance units, each intended to support ten thousand men for 30 days. Designed for World War II, these units contained much sophisticated equipment but lacked items essential in Korea. At one point Captain Gans, the Eighth Army medical supply officer, had to borrow opium and paregoric to treat dysentery from the South Korean medical depot at Taegu.

Requisitions were forwarded to the zone of interior with mechanical regularity. Yet in the early days of the war much depended on a kind of large-scale scrounging. Quartermasters found quantities of bedding for the hospitals. Air Force hot-air blowers, designed to keep engines operating in below-zero weath-

⁵First quotation from Interv, Samuel Milner with Lt Col Lynn B. Moore, MSC (hereinafter cited as Moore Interv), 28 Jul 66, p. 12, AMEDD Oral History file (Moore). Second quotation from EUSAK, Annual Report of Medical Service Activities, 1950, p. 29. Both in HRB. See also Supply Division, OSG, History of the Korean Conflict, 25 Jun 50–8 Sep 51, pp. 4–8, file 314.7–2 (Army Medical Service Activities, 25 Jun 50–8 Sep 51); Ltr, Col E. W. Partin (Ret.) to Col. R. L. Parker, MSC, Historical Unit, U.S. Army Medical Service, 31 May 61, HSF (Partin–1961). Both in HRB.

⁶EUSAK, Annual Report of Medical Service Activities, 1950, p. 27, HRB.

er, served as heaters in hospital tents. Ordnance shops fabricated truck litter brackets, and the naval hospital at Yokosuka made up deficiencies in items critically short. General Walker told his surgeon to call on the other technical services for anything he needed. Eighth Army medical supply officers on their own "would trade or borrow . . . and get what was needed overnight."⁷

"The transportation of materiel to Korea," reported the Far East Command at the end of 1950, "has been uniformly excellent since the beginning of the war." Air, water, and rail systems of both Japan and Korea contributed to the flow of medical supplies. Lying only 140 miles from Japan, Korea could be reached by air in forty-five minutes, and this fact alone made the more spectacular achievements of emergency supply—like those of emergency evacuation—possible. In early July, however, a more conventional system began to take form. Ships moved the bulk cargo, and a depot was needed at Pusan to receive and distribute. On 8 July a platoon of the 8065th Army Medical Depot, formed from Yokohama Medical Depot personnel, was organized and shortly afterward dispatched. For a month this group of four officers and thirty enlisted men provided medical support to the Eighth Army, other U.N. forces, and the ROK Army. On 10 September the 6th Army Medical Depot arrived in Pusan from Texas and absorbed the personnel of the 8065th. Henceforth, the depot's twelve officers, five warrant officers, and two hundred enlisted men carried out such functions as storage, maintenance, issue, and repair, as well as the manufacture of eyeglasses. Forward of the depot the movement of medical supplies to requisitioning organizations depended largely on the Korean railroads, operating under the Eighth Army's Transportation Section. Perhaps not since the Civil War had railroads so directly served American troops on the battlefield. Here were the workhorses of the system, which moved materiel forward as they carried casualties to the rear.⁸

As the expedients of the early months gave way to system and routine, the whole logistical structure matured. On 4 July the Far East Command had established the Pusan Base Command under the United States Army Forces in Korea. By that time port operations were under way, and a melange of personnel—24th Division officers and men, the Advance Command and Liaison Group transportation officer, United States Military Advisory Group officers and civilians who had stayed to help, Korean civilians, and convalescents discharged from military hospitals—assembled in rough and ready fashion to organize traffic and to help unload ships. On 13 July the Eighth Army, taking over in Korea, established the Pusan Logistical Command, a table of organization and

⁷Quoted words from Dovell Interv, 21 Sep 66, p. 11, HRB. See also Laurence J. Potter, "Medical Service in Support of Operations in Korea," Address before the American Pharmaceutical Association, Technical Information Office, OSG, release, 30 Mar 51; Gans Interv, 29 May 66, pp. 5-6, AMEDD Oral History file (Gans), HRB.

⁸Quoted words in FEC, Annual Report of Medical Service Activities, 1950, p. 124, file 319.1-2 (FEC) Far East-1950, HRB. The complement of the depot company fluctuated; the figures given are table of organization and equipment. See also 6th Army Medical Depot Historical Report, 1950, pp. 1-3, file 319.1-2 (6th Army Medical Depot) Far East-1950, HRB; 3d Transportation Military Railroad Company Historical Report, June 1950-September 1953, p. 21, as cited in 8086th Army Unit, Military History Detachment, "Transportation of Supplies, 1 July 1951-31 July 1953," Ms no. 8-5.1A AA,B, RG 319, MMHB.

equipment unit that absorbed the personnel of the base command plus additional manpower from service units in Japan. But transporting supplies, assisting refugees, guarding prisoners of war (POWs), operating additional ports in the south, and—after the Inchon invasion—supervising the newly established 3d Logistical Command on the west coast soon overburdened the Pusan Logistical Command. On 19 September the 2d Logistical Command, an expanded organization, took its place as a major subordinate command of the Eighth Army. Until the creation of the Korean Communications Zone (KCOMZ) two years later, the 2d Logistical Command remained in charge of the Korean rear areas. Its authority expanded as the front moved forward and its people provided support for the Eighth Army and, while it existed as a separate command, for X Corps as well.⁹

Water, Blankets, and Litters

Two matters of particular interest to the medics were the supply of potable water to the troops and the establishment of a property exchange system that would ensure an adequate supply of litters and blankets in the forward hospitals and aid stations. Both were basic to health and survival, and both entailed special problems under Korean conditions.

Water supply was especially important because most of the available Korean sources were contaminated. Halazone tablets were unsatisfactory—the 406th Medical General Laboratory randomly tested the tablets for quality, but many that were worthless slipped through anyway—and North Korean infiltration and guerilla attacks disrupted supply lines and isolated units. Municipal water supplies in Korea were and remained insufficient because of power and equipment failures. The rapid spread of common diarrhea was not surprising among troops dependent upon “an inferior sterilizing agent to disinfect a polluted water supply.” Prime responsibility for supply belonged to Corps of Engineers water points, which, as the tide of battle stabilized and then turned, proved increasingly adequate for the troops both in quantity and quality. The Medical Service cooperated closely with the engineers, checking the water points frequently to ensure uniform standards of chlorination. During cold weather the engineers enclosed the points, either in tents or in improvised wooden shelters, and used immersion heaters to warm unit water trailers. On the whole, enteric diseases, although very common, were relatively mild among Americans fighting in Korea, and by the end of 1950 the Eighth Army surgeon could speak with guarded satisfaction of the water supplies available to the troops.¹⁰

Far less successful were efforts to arrange a workable system of property exchange. The rules for maintaining a supply of litters and blankets were based upon the standard chain of evacuation. As the wounded arrived at a new unit,

⁹USAFFE and EUSAR, “Logistics in the Korean Operations,” vol. 1, pp. 5–19, Ms no. 8–5.1A AZ, RG 319, MMHB. Functionally, the logistical command resembled the advance section of the communications zone in the European Theater of Operations during World War II.

¹⁰Quoted words in FEC, Annual Report of Medical Service Activities, 1950, p. 78, HRB. See also EUSAK, Annual Report of Medical Service Activities, 1950, p. 41, HRB.



WINTER SUPPLIES

the litters and blankets of the previous aid station or hospital were to be returned on a one-for-one basis, without paperwork or other formality. Korean conditions defeated this system. Planes flying in supplies were filled for the return journey with wounded, many still on their litters, and dispatched to Japan. The wounded went to hospitals, the planes were reloaded with high-priority war materiel, and the blankets and litters remained behind. At Tachikawa Air Base Colonel Partin, the FEC medical supply officer, "found a veritable mountain of litters" unloaded by the Air Force and left there.¹¹ Japan, in turn, was shipping extraordinary numbers of casualties to the United States under similar conditions. On balance, blankets and litters accumulated where they were not needed and disappeared from the Far East Command where they were. In addition, large numbers were lost in battle or by pilferage.

Efforts by the Far East Command to return as many as possible to Korea only revealed that a loss of some ten thousand litters had occurred in the first three months of combat. Other parts of the command were called upon for aid. Okinawa shipped four thousand during September, and the surgeon general ordered an airlift of four thousand more from the zone of interior. Advance platoons sent forward by the 6th Army Medical Depot maintained near the front stocks of fast-moving items, including blankets and litters. Though the

¹¹Gans Interv, 29 May 66, pp. 9-10, HRB.

shortage was alleviated, by the end of the year General Hume was obliged to report that "no amount of effort in the last six months has produced a workable system for exchange of property on transfer of patients." Only when the shortage of litters and blankets in forward areas became critical did their priority rise to the point that airspace could be obtained for shipment. Like an ill-regulated thermostat, the logistical system responded only to crisis. The result was a "continual shortage in combat areas" of these basic and absolutely essential items.¹²

Personnel

Supplies meant little unless skilled hands were available to use them for the benefit of the wounded. The Korean crisis appeared to have been contrived by a malign fate at the precise moment when medical officer strength in the Far East Command "was at the lowest [point] since the beginning of the occupation." In many ways skilled enlisted men were even more difficult to obtain than general duty physicians (though certain types of physician specialists were the most difficult of all). Yet strength as well as weakness characterized the Medical Service, and at the end of six months of sometimes desperate improvisation the command declared that the medics were "in many respects, better prepared for immediate action than was the case at the time of Pearl Harbor and perhaps for about one year thereafter." So paradoxical a conclusion deserves further analysis.¹³

Immediately before the outbreak of war the Far East Command lost two groups of medical officers—not only its remaining Army Specialized Training Program graduates but also some participants in the civilian internship program who had completed their obligation of two years' active service for every year of government-supported training. The census of medical officers fell from 264 in January 1950 to 197 in June. Still more striking, however, was the comparison with May 1949, when 330 had served in the command. (No equivalent reduction had taken place in the FEC personnel they served.) The command found only a partial answer in a variety of expedients aimed at persuading nonregular officers to extend their overseas service. Civilian physicians were hired, and in mid-May fifty-four residents arrived from the zone of interior on three months' temporary duty (TDY). Still, continuing losses reduced command medical officers to half the table of organization number. Anticipating the problems, the Department of the Army in April and May put 147 medical officers on special orders, reassigning them to the Far East Command in August and September. Most of these replacements were young men, participants in the civilian internship program, who had had no prior contact with military service. For a variety of technical reasons having to do with the terms of their enlistments, the length

¹²Both quotations from FEC, Annual Report of Medical Service Activities, 1950, p. 125, HRB. See also EUSAK, Annual Report of Medical Service Activities, 1950, p. 30; FEC, Report of ETMD, August 1950, pp. 13–14. Both in HRB.

¹³FEC, Annual Report of Medical Service Activities, 1950, HRB. First quotation on p. 142; second quotation on p. 151. Except as otherwise noted, the following section is based on this report.

of their overseas tours was short. The prospect was that the regular officers, with their longer tours and generally wider experience, would have to juggle short-term colleagues with excellent professional backgrounds but, very often, with no Army experience whatever.

Inevitably, a personnel crisis followed the outbreak of war. Understrength divisions had to be made operational. Medical field units had to be formed. Already understaffed, the hospitals in Japan gave up both officers and enlisted men. At the same time, casualties began to arrive from Korea, and the hospital system was faced with the need for expansion to handle an anticipated flood later on. In short, the first two weeks of July brought a totally impossible situation.

On 1 July the Far East Command asked the Department of the Army to ship the replacements at once, and by the thirteenth the movement was under way. The surgeon general added any other physicians he could spare, and by mid-August 240 had arrived. Meanwhile, on 2 July General MacArthur received authority to impose a personnel freeze that, among many other effects, held the residents on TDY. (An influx of replacements permitted their release in mid-November, when the war appeared to be won.) These actions ended the immediate crisis. As the FEC surgeon reported, "We no longer had our backs to the wall as was the case during the first two weeks of July." The Chinese intervention then brought a new crisis. In late November, as the hospital census soared, doctors were again in urgent demand. The year ended in a new personnel freeze, with uncertain prospects for the future.¹⁴

Of great importance during these successive shocks was the assignment of ninety-eight Navy doctors, who arrived in the Far East Command during November and December. The Navy attached no strings to the use of these men, most of whom went to the Eighth Army and X Corps in Korea. Wearing Army clothing for lack of any Navy uniform appropriate to their new duties, they were, as General Hume wrote, "indeed welcome,"¹⁵ though no one anticipated that they could be retained for long.

Between the Navy doctors, most of them residents, and the Army's own residents and interns, the general picture was one of innocents in the field. The Far East Command remarked that the new doctors' lack of military experience might have been "a serious handicap to their medical mission and a threat to their very existence in the combat areas in Korea." Mitigating the situation was the military experience of Medical Corps officers (MCs) in command positions and of many Army Nurse Corps officers (ANCs), Medical Service Corps officers (MSCs), and enlisted men. The Second World War was only five years in the past, and most regular officers and many reservists as well had battlefield experience. The first commander of the 8055th MASH later recalled that his hospital had survived the opening months in part because he had "learned to run in the Battle of the Bulge." The commanders of the 8063d and 8076th MASH were veterans and had prior Korean service as well.¹⁶

¹⁴*Ibid.*, p. 144, HRB. See also EUSAK, Annual Report of Medical Service Activities, 1950, pp. 19–20, HRB.

¹⁵FEC, Annual Report of Medical Service Activities, 1950, p. 147, HRB.

¹⁶*Ibid.*, p. 148, HRB.

Hence, lucky newcomers diffused as junior officers into units whose senior members were more familiar with the ways of war than many of the regular officers of 1941. Young men “wearing their first uniforms” were teamed with veterans and many of the veterans, graduates often of training programs similar to those that had drawn the civilians into the service, were exceptionally well qualified to treat the injured as well as to administer. Though casualties exceeded all predictions, hospital death rates were the lowest in the history of warfare. At a time when the draft had not yet come to solve the problem of procuring doctors, this accomplishment belonged to the Medical Service almost alone, to its cadre of experienced officers and men, and to its highly educated newcomers who occupied the most forward positions. “I feel,” wrote Dr. Howard D. Fabing, consultant to the surgeon general in neurology and psychiatry, after a tour of the Far East Command, “that [the Army residency training program] saved the bacon in the Korean War, and if it can never demonstrate another value, this alone proved its worth.”¹⁷

All, however, were not fortunate. Young physicians with little rank too often found themselves in forward positions, faced with the task of organizing the most difficult of medical maneuvers, a retreat burdened with casualties. If this was sometimes the fate of the medical officer, that of the veteran Medical Service Corps officer or enlisted man was occasionally to be placed in a position he was not clinically qualified to fill. Instances occurred when the duties of battalion surgeon devolved upon enlisted men. The Medical Detachment, 38th Field Artillery Battalion, 2d Infantry Division, did not have a single commissioned officer, either Medical Corps or Medical Service Corps, for its first six months in combat—which included the Chinese breakthrough at Kunu-ri. The first sergeant of the detachment acted as surgeon, daily treating casualties from his own battalion and as many as 30 infantry patients as well. Similarly, M. Sgt Jerry J. Novosad, surrounded for three days at Chipyeong-ni, saw the units caught in his pocket suffer 556 casualties. He cared for all these men in the 23d Infantry collecting station, which had no assigned officers at all. As the station was without protection from incoming mortar rounds, he walled his tents with railroad ties. He gave his patients penicillin and painkillers; dressed their wounds; when necessary, administered whole blood; and provided two meals a day. Besides Novosad, the heroes of the piece were the helicopter pilots who, in defiance of standard operating procedures, flew into the embattled enclave to evacuate the most serious cases—100 in all—which even Novosad could not handle. In Korea such situations too often resulted, not from the accidents of war, but from a continuing deficiency in the number of doctors and in the quality of their training.¹⁸

¹⁷First quotation from Telecon, author with Isaac J. Tender, October 1981. Second quotation from Rpt, Howard D. Fabing, M.D., 30 Dec 50, sub: Recent Trip to Far East Command, p. 13, file 730 Neuropsychiatry (Consultants Visits) Far East 1950–51, HRB.

¹⁸Army Field Forces Observations, FEC, March 1951, Encl to Ltr, Brig Gen Robert P. Williams, MC, Chief, Medical Section, Office of the Chief of Army Field Forces, to Deputy Surgeon General, DA, Attn.: Maj Gen George E. Armstrong, MC, 12 May 51, file 319.1 (FEC) AA, 1951–52, Box 69, Accession no. 56A–179, RG 112, WNRC.

At higher levels the Medical Service during the early period in Korea remained, despite the residency programs, persistently short of certain kinds of physician specialists. It simply had no way, using its own resources, to approximate the riches of specialized knowledge that a World War II-style draft could muster. Hence, specialists in certain critical areas—neurology, urology, anesthesiology—remained in short supply, and the professional training of others was deficient. At the start of the war the Far East Command had only one general surgeon who was board certified, and the surgeons who arrived in August, though better trained clinically, lacked battlefield experience. As 1950 drew to a close, shortages were relieved in most specialties, other than neurosurgery, in the hospitals of Japan. The command kept a card file on the professional training of new physicians and assigned skilled men where their abilities could be used most fruitfully. Finding neurosurgeons to serve at forward posts in Korea, however, was a job for the future.¹⁹

The inexperience of so many new MCs meant opportunities for the other corps. The number of ANCs and MSCs had never fallen to the critical level reached by physicians, though nurse anesthetists were in short supply. For both, wartime meant a drastic increase in demand. As its medical management and housekeeping functions expanded, the Far East Command asked for additional MSCs from the zone of interior, and their duties multiplied even beyond the diversity of World War II. Almost without exception, the MSCs in the Far East were veterans with five to ten years' service already behind them. A major source of stability and continuity, they commanded medical units, provided a fund of experience for new MCs to draw upon, and trained fresh arrivals of all ranks. By early 1951 the MSCs would command the medical battalions of four of the six U.S. divisions. Nurses, too, were relatively more abundant than doctors and the majority on duty in the command had served during World War II. The first shock of combat, when eighty-seven ANCs were sent to Korea, did not diminish the care available in the hospitals in Japan. However, as casualties mounted in July and no new nurses appeared, an acute shortage developed. Relief came on 14 August with the arrival of the first shipment of ANCs from the United States. Nurses also began to arrive from other U.N. countries; some Thai nurses served for a time with the 8054th Evacuation Hospital, as others did in Japan, releasing ANCs for duty in Korea. Except for the crisis period in July, when there seemed to be enough of no one, the ANCs and MSCs were adequate in numbers. On account of their broad military experience, they played a crucial role in the functioning of the Medical Service.

Trained enlisted men were both necessary and in short supply. Moreover, the supply improved more slowly than among the officers. Understaffed and overworked, the enlisted component in both units and hospitals was reported to be "wearing out from long hours of hard work in trying circumstances. . . ." For a time the arrival of new medical units depleted instead of expanding the supply. A long list of such outfits—the 121st and 171st Evacuation Hospitals, the 4th and 64th Field Hospitals, the 1st MASH, the 559th and 560th Medical

¹⁹Surgeon's Circular Letter 6, no. 3, Medical Section, FEC, 1 Mar 51, pp. 52–53, file 461 (Circular Letters) FEC, HRB.

Ambulance Companies, the 514th and 618th Medical Clearing Companies (Separate), plus a miscellany of smaller organizations—showed up in the Far East Command with “glaring shortages in enlisted personnel.” The 560th Medical Ambulance Company alone was short fifty-one enlisted men; the two field hospitals could staff only two platoons each. “In order to avoid committing crippled units to action,” the command complained, “these units were made operational through pulling medical service enlisted men from hospitals in Japan that, due to their patient census, could ill afford to lose a single man.” The Medical Replacement Training Center, set up at Fort Sam Houston, Texas, on 22 August, partly relieved the problem. Yet from the beginning of the war until the end of 1950, the number of enlisted medics had slightly more than doubled in a command where the total number of non-Korean ground troops had increased by almost four times.²⁰

Training the newcomers was another critical problem in a service where skill and intelligence were at a premium. Nurses in Korea complained that their “greatest difficulty . . . was with the untrained corpsmen,” who, without a medical background, struggled to acquire basic skills on the fighting front. Hence, the hospitals in Japan set up a refresher course for wardmasters and ward attendants. At year’s end the Eighth Army counted about 9,500 enlisted medical corpsmen as against an authorized strength of 10,264.²¹

Such were the personnel resources of the command. A method of handling them with considerable portent for the future appeared during 1950 with the beginning of a theater rotation policy for nurses and doctors. The reasons given for selecting the two most professional corps for the experiment were quite different. The Far East Command viewed rotation of nurses as “obvious,” based on its “experience that women officers, because of their physical limitations, cannot be expected to undergo for prolonged periods of time the hardships and adverse environmental conditions on equal terms with men.”²² Unmentioned in official reports was the fact that the women officers were volunteers, not subject to the pressures of the draft—a factor that already had influenced the granting of rotation rights during the peacetime occupation of Korea.

The Far East Command’s chivalric treatment of its female officers was made easier by the fact that nurses, with few exceptions, repeatedly chose duty in Korea over safer and more comfortable stations. “We are faced,” wrote General

²⁰First and second quotations from FEC, Annual Report of Medical Service Activities, 1950, p. 151. Third quotation from *ibid.*, p. 152. Both in HRB. See also EUSAK, Annual Report of Medical Service Activities, 1950, p. 23, HRB; Weekend Letter no. 5, Col R. H. Eckhardt for Maj Gen Edgar Erskine Hume, Chief Surgeon, Medical Section, FEC, to Maj Gen R. W. Bliss, Surgeon General, DA, 8 Sep 50, file 200 (Personnel Letters Between SGO and Medical Section, FEC), Box 3099 (Medical Section, FEC, General Records, 1950), RG 338, MMFB. On the Medical Replacement Training Center, see Education and Training Division, OSG, History of the Korean Conflict, 25 Jun 50–8 Sep 51, pp. 1–3, file 314.7–2 (Army Medical Service Activities, 25 Jun 50–8 Sep 51), HRB.

²¹Quoted words from FEC, Report of ETMD, July 1950, p. 38, file 350.05 (FEC) 1950, HRB. See also Weekend Letter no. 5, Eckhardt for Hume to Bliss, 8 Sep 50, RG 338, MMFB. The increase of ground troop strength, U.S. and U.N., was from 51,745 in July to 208,265 at the end of December. See Statistical Summary, Program Review and Analysis Division, Office of the Comptroller of the Army, 7 Oct 54, sub: ROK and UN Ground Forces Strength in Korea, 31 July 1950–31 July 1953, Geographic V file 320.2 (Strength), HRB.

²²FEC, Annual Report of Medical Service Activities, 1950, p. 154, HRB.



ARMY NURSES OF THE 121ST EVACUATION HOSPITAL

Hume at one point, “with the happy problem of having far more volunteers for Korea than can be accommodated. Almost all the ANC officers want to leave their relative comforts in Japan and go to the uncertainties of Korea.” Nevertheless, the Army Nurse Corps itself sought special treatment, for the rotation policy was established on 19 October at the request of the chief nurse. Henceforth, ANCs with ninety days of duty in Korea were scheduled for transfer to the JLCOM hospitals. Ninety nurses had rotated by year’s end. “We have not required any nurse wishing to remain to leave Korea,” Hume summed up to the surgeon general, “but those who feel that they should be replaced will be. After all, the war has been going on between four and five months and these women have had a very rugged time, as you well know.”²³

By the end of 1950 plans also had matured to rotate medical officers to Japan after six months in Korea. The mechanics of the process were similar. As in the case of the nurses, the Far East Command required replacements to be actually on hand. The justification, however, was quite different. Here the aim

²³Quotations from Weekend Letter no. 4, Maj Gen Edgar Erskine Hume, Chief Surgeon, Medical Section, FEC, to Maj Gen R. W. Bliss, Surgeon General, DA, 5 Sep 50, file 200 (Personnel Letters Between SGO and Medical Section, FEC, General Records, 1950), RG 338, MMFB, and from extract of Ltr, Hume to Bliss, 29 Nov 50, HSF (Hume-1950), HRB. See also Headquarters, Japan Logistical Command (hereinafter cited as JLCOM), Command Report, October 1950, Narrative Summary, pp. 20-22, file AYUT-8000 (JLCOM, Command Report, Oct 50), Box 4614 (JLCOM, AYUT-8000, Narrative w/encls 1-9, Oct 50), Entry 429, RG 407, and Msg, CINCFE ZX 21376 to CG, ARMY EIGHT, 19 Oct 50, Encl 4 to Weekend Letter no. 7, Hume to Bliss, 27 Oct 50, file 200

was professional renewal through contact with hospital work, and the plan was to rotate first the divisional and other unit officers because "they were the furtherest [*sic*] removed from intensive professional work of all those on duty in Korea." While other corps could not be rotated "due to the logistical and personnel problems involved," the command did put into effect toward the end of the year a plan to allow all officers and enlisted men in Korea to return to Japanese centers to enjoy five days of "rest, recreation and recuperation."²⁴

The personnel system during 1950 could record as its major achievements the survival and growth of medical support for the Eighth Army and its backup in Japan under the two great shocks of the North Korean invasion and the Chinese intervention. In conditions that twice approached crisis, men and women were found to fulfill the mission of evacuating and treating the wounded and sick. In the doctor draft, enacted during August, and in the beginnings of the rotation system, durable elements of what would become the Korean norm emerged. But the first influx of drafted doctors was not expected until January 1951. During 1950 the Medical Service was thrown largely on its own resources, and its rotation policy was ad hoc and related to the special situation of nurses and doctors. The maturing of the system lay in the future.

Preventive Medicine

Meanwhile, on the ground in Korea, the stabilization of the rear areas and the arrival of new units allowed the growing medical establishment to prevent and treat disease with greater assurance than at any time since the onset of the war. Preventive medicine was virtually impossible during the weeks of withdrawal and defeat. The shock was great to troops newly arrived from Japan. A primitive battle-wracked Korea, where even the elementary improvements of earlier years were lost, took a heavy toll of illness on the men who had come to help defend it. Nevertheless, efforts at control began early, for malaria survey and control detachments were among the first units to enter Korea in July.

Heat, multiplying insects, and impure water provided obvious sources of disease. Inspection during August by the sanitary engineering and preventive medicine consultants indicated that water purification was still a problem, and that, though mosquitoes were few, fleas were a "universal plague." Patients evacuated from the front line were infested, as were the doctors, nurses, and attendants working over them. DDT dusting and spraying of clothing, beds, billets, and hospital wards was in progress, but airplane dusting, begun in late July, was interrupted on occasion because of equipment breakdowns. Fly control was judged "an insurmountable task in this [Korean] area." Lack of personnel meant that Korean KPs were working in Army messes; their personal hygiene was judged "extremely poor." Carriers were many for the multiple ills of Korea. Taking into account men, rodents, and insects, diseases were borne to the troops on two, four, and six legs, as well as on the wing.²⁵

(Personnel Letters Between SGO and Medical Section, FEC), Box 3099 (Medical Section, FEC, General Records, 1950), RG 338. Both in MMFB.

²⁴FEC, Annual Report of Medical Service Activities, 1950, p. 156, HRB.

²⁵Quoted words from FEC, Report of ETMD, August 1950, p. 9, HRB. See also EUSAK, Annual
(Continued)

Diarrheal disorders formed one of the greatest single groups of medical disabilities. Shigellosis, a form of bacillary dysentery, was the commonest. Symptoms of enteric cramps and diarrhea added to the other woes of fighting men during the Pusan Perimeter battles, the recorded incidence reaching 120 cases per 1,000 troops per annum during August. Thereafter, the diarrheal disorders declined in response to many factors, among others improved engineer water supplies and increasingly rigorous medical discipline.

Even more common than enteric problems during September were fevers of undetermined origin. These were believed to include a number of viral ills and, for a time, were a serious cause of disability. Incidence reached what the Eighth Army surgeon called the "rather astounding figure" of 138.9 admissions per 1,000 troops per annum. Mixed in were cases of malaria that were atypical or resisted diagnosis, and possible cases of enteric fever and dengue. A fundamental factor in the rise of this catchall category was the difficulty of obtaining proper laboratory analyses under battlefield conditions. With the onset of cool weather, the incidence of fevers dropped off sharply to a low of 14.1 per 1,000 in December. These two general categories of illness—enteric and febrile—together with a third, psychiatric problems, represented the most important causes of lost manpower to the U.N. forces during the early months in Korea.²⁶

Malaria was not as great a problem as originally feared. Five cases occurred in July, 129 in August, and 225 in September. Though prophylaxis as always proved difficult to enforce under battlefield conditions, the Medical Service made every effort to do so. Additionally, two control units began operating behind the lines in July, destroying not only mosquitoes but also flies and fleas. Some used Japanese-made foggers and motor dusters, which proved to be "highly satisfactory and effective" substitutes for American machines. After the reconquest of Seoul, Air Force planes began an aerial spraying program using specially equipped C-47 aircraft. Cases of malaria reached their high of 29 per 1,000 troops per annum when U.S. soldiers were crowded into the Pusan Perimeter with hundreds of thousands of infected Korean civilians, who formed the chief reservoir of the disease. On the whole, however, the combination of chloroquine prophylaxis and early, heavy use of insecticides held malaria to a lower incidence than expected, given Korea's disease environment and the conditions of war. The disease declined after the breakout and ended with the coming of winter.²⁷

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Report of Medical Service Activities, 1950, p. 32, HRB; Medical Section, EUSAK, Summary of Activities for Period 25 June–13 July 1950, Encl 20 to EUSAK War Diary, file 108 (Sec. 1, Prologue, EUSAK War Diary, 25 Jun–12 Jul 50), Box 1081 (War Diary, EUSAK, Table of Contents, Secs. 1–2, Prologue, Summary, Jul 50), Entry 429, RG 407, MMFB.

²⁶Quoted words from EUSAK, Annual Report of Medical Service Activities, 1950, p. 35, HRB. See also 406th Medical General Laboratory, Report of ETMD, September 1950, p. 10; "A Summary of Medical Experience in Korea, July 1950–December 1952," reprinted from *Health of the Army*, January, February, and March 1953, file 720 (Health of the Army–Summary of Medical Experience) Korea–Jul 50–Dec 52, HRB.

²⁷Quoted words from 38th Malaria Control Detachment, Annual Report of Medical Service Activities, 1950, file 319.1–2 (38th Malaria Control Detachment) Far East–1950, HRB. See also 406th Medical General Laboratory, Report of ETMD, September 1950, p. 3. All positive tests for malaria showed the culprit to be *Plasmodium vivax*. See also 207th Malaria Survey Detachment,



BATTALION AIDMAN VACCINATING SOUTH KOREAN TROOPS

The detachments worked as well to control other insect-spread diseases, dusting thousands of POWs to reduce the threat of typhus and heading off an outbreak of mosquito-borne encephalitis around Chinhae on the south coast of Korea. The 357 cases of encephalitis that occurred anyway were mostly among troops on the front line where, for obvious reasons, the environment was beyond control. Victims were sent to Japan, where the 361st Station Hospital at Tokyo became a center for the study and treatment of the disease. In similar fashion the 35th Station Hospital in Kyoto specialized in hepatitis, an ill-understood viral disease that was endemic in Korea. Other diseases meant little in terms of the numbers of Americans who were stricken: a few cases of smallpox; one fatal case of tetanus; two cases of diphtheria; twenty-one possible cases of dengue; eight of relapsing fever; and seven of meningitis. At least one death from polio also occurred. Typhus and typhoid were nonexistent among Americans, as were cholera and plague.²⁸

Annual Report of Medical Service Activities, 1950, file 319.1-2 (207th Malaria Survey Detachment) Far East-1950; FEC, Report of ETMD, August 1950, p. 15; 406th Medical General Laboratory, Annual Report of Medical Service Activities, Professional Section (Annual Historical Report), 1951, pp. 14-18, file 319.1-2 (406th Medical General Laboratory) Far East-1951; EUSAK, Annual Report of Medical Service Activities, 1950, pp. 45-47. All in HRB.

²⁸FEC, Annual Report of Medical Service Activities, 1950, pp. 23-25, 52-53, 67-68, HRB. In December, arrival in Korea of the 37th Preventive Medicine Company was reported. See Surgeon's

(Continued)

The immunization programs that played so important a role in controlling disease were not confined to those in Korea. Early in the war, thousands of Korean recruits began to arrive in Japan for training and integration into units of the American Army. These young men, known as the Korean Augmentation to the United States Army (KATUSAs), were destined to live in close contact with American personnel. Massive immunizations helped to prevent the introduction of disease either into the training camps or among the Japanese population. Some fifty thousand KATUSAs received smallpox vaccinations and doses of typhoid-paratyphoid vaccine, as well as typhus and cholera shots. Although the American soldiers already had received the Army's usual battery of shots in the United States, the dangers in Korea were such that they, too, were given new immunizations for typhus and cholera, revaccinations in cases of need, and tetanus toxoid to protect against one of the commonest of battlefield contaminations. Meanwhile, during each day of August the 8054th Evacuation Hospital immunized about four hundred recruits for the ROK Army.²⁹

As in the days of peace, the work of the Veterinary Corps was exceptionally important. The corps' food inspection units provided the only medical control on the quality of foodstuffs shipped into Korea. The 95th Veterinary Food Inspection Detachment was typical. With one officer and seven enlisted men the unit arrived at Pusan in early July and was attached to the 8054th Evacuation Hospital for billeting. During the chaotic period at the port its personnel struggled to inspect incoming goods, to sort out what was edible for issue to the troops, and to prevent pilferage by Korean laborers. The arrival of the 476th Veterinary Food Inspection Detachment and of another veterinary officer with the port unit finally assured an adequate number of personnel, even though the 95th's commander, Maj. Jack E. Wittrock, feelingly described his struggles with laborers who spoke no English, disintegrating cartons of food, a variable supply of electric power, and canned goods of uncertain quality. Nevertheless, such work by very small numbers of Medical Service personnel made a large and essential contribution to the health of the troops.³⁰

A sign of changing conditions in Korea was the evolution in the venereal disease (VD) situation.³¹ During July and August most cases among Americans in Korea resulted from the troops' last flings in Japan. During September, rates

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Circular Letter 5, no. 12, Medical Section, FEC, 1 Dec 50, p. 3, file 300.5 (Circular Letters) FEC, HRB. The work of this company is discussed in Chapter 8 of this volume.

²⁹JLCOM, Annual Report of Medical Service Activities, 1950, p. 9, file 319.1-2 (JLCOM) Far East-1950; EUSAK, Annual Report of Medical Service Activities, 1950, pp. 40-41; FEC, Annual Report of Medical Service Activities, 1951, pp. 52-53, file 319.1-2 (FEC) Far East-1951. All in HRB. See also Surgeon's Weekly Letter, 22 Dec 50, pp. 3-4, tab 3, document 5, Medical Section, JLCOM, Command Report, December 1950, Supporting Documents, file AYUT-8000, Annex 24 (Medical Section, JLCOM, Dec 50), Box 4627 (JLCOM, AYUT-8000, Annexes 19-28, Dec 50); 8054th Evacuation Hospital, Semimobile, Report of Public Health and Sanitation Activities, August 1950, file MDEH-8054 (Report of Activities, 8054th Evacuation Hospital, Jul-Aug 50), Box 4715 (Nonorganic Units, MDDP-4 to MDGH-457, 1949-50); Medical Section, EUSAK, Historical Report, 22 Jul 50, Encl 20 to EUSAK War Diary, file 108 (War Diary, EUSAK, 22 Jul 50), Box 1084 (EUSAK, Sec. 3, War Diary, 21-23 Jul 50). All Entry 429, RG 407, MMFB.

³⁰66th, 95th, 150th, and 476th Veterinary Food Inspection Detachments, Annual Reports of Medical Service Activities, 1950, files 319-1.2 (66th VFID), (95th VFID), (150th VFID), and (476th VFID) Far East-1950, HRB.

³¹This and the following paragraph are based on EUSAK, Annual Report of Medical Service Activities, 1950, pp. 36-40, HRB. First quotation on p. 39; second quotation on p. 36.

were quite low, reflecting the rapid movement of forces through areas almost devoid of civilians. Beginning in October, venereal disease seemed to be acquired largely in Korea, often in cribs so unsanitary that a medical officer was moved to wonder "how an American soldier can frequent these places." The decline of formal brothels in favor of assignations in buildings that existed primarily for other purposes made the posting of off-limits signs virtually useless. In Pusan, for example, an area with a large concentration of troops and—according to one estimate—some eight thousand prostitutes, dance halls opened to accommodate the troops. After visiting such establishments, soldiers retired with chosen partners to finish the evening in a crib, private home, hotel, or paddy field. Prophylactic stations had to provide showers and DDT dustings in addition to specific anti-VD services, because other diseases, such as typhus, also were transmitted during sexual contact. The social breakdown associated with the war, the poverty of the refugees, and the influx of professional prostitutes all contributed to the spread of venereal disease.

At the same time, wartime conditions made the gathering of accurate statistics impossible. The Eighth Army reported that VD rates declined from 183 cases per 1,000 troops per annum in 1949 to 143 in 1950. The reduction was attributed to the war, which removed large numbers of men to front-line locations where the opportunity for sexual contact was small. However, the Eighth Army surgeon admitted that the figures were "not a true indication of the incidence among the troops in Korea" and that they were reported for whatever they might be worth.

Overall, the record of preventive medicine under the near impossible conditions of 1950 was by no means a poor one. With every circumstance ripe for major disease outbreaks, none occurred that caused significant loss of life or danger to the operations of the military forces. Into this result had gone a substantial measure of good luck and a vast amount of hard work. But the course of the war was a fundamental adverse factor. Until the fighting lines stabilized, the effort to prevent disease would remain a hit-or-miss affair.

Hospitalization and Evacuation

Besides moving supplies and replacements forward and seeking to establish medical discipline, medics moved the sick and injured out. In every respect the evacuation system remained expedient and informal, yet by the end of 1950 signs of greater order and sophistication had appeared.

Within Korea the major means of moving large numbers of wounded remained the railways. Early hospital trains were improvised, consisting largely of converted boxcars and coaches, plus a few ancient hospital cars. One job of the malaria control detachments was to destroy the abounding population of fleas and lice that inhabited such vehicles. At Taegu a freight car was kept stocked with C-rations, fruit juice, litters, and blankets to supply the hospital trains as they were made up. Two sandbagged flatcars were attached to each train. Equipped with machine guns and manned by twelve military policemen carrying automatic weapons, the flatcars were the major protection against guerillas, though the red crosses were painted out to reduce the possibility of attack. In this condition, with a single nurse to care for the patients and a corpsman or two to assist her, a train was ready for its run to Pusan.

This rough-and-ready period of medical railroading did not last through 1950. On 1 August the Office of the Surgeon General received from General MacArthur a request for two hospital trains for use in the Far East. Though American trains could not use the narrow Japanese tracks, Korean tracks were standard gauge. Toward the end of the year hospital cars began to arrive from the zone of interior, and by year's end two hospital train units were running trains on a continuous shuttle between Pusan and the front-line hospitals. Meanwhile, other means of transport had developed to assist the railroads. Ambulances, litter jeeps, helicopters, and a variety of fixed-wing aircraft played essential roles. The fixed-wing craft operating within Korea were controlled by the Combat Cargo Command of the Far East Air Forces. The Air Force retained a monopoly of these planes, and moved significant numbers of wounded within the country, as well as from Korea to Japan. On the ground the litter jeep quickly won the approval of many medical officers, not merely as a field expedient to replace unavailable ambulances but as a preferred vehicle because its low profile made it a less inviting target. Whether the injured moved by rail, road, or air, the formal evacuation policy established at twenty-one days in July and expanded to thirty days in August meant little in practice. As the Eighth Army admitted, the actual disposition of the wounded varied from day to day with the tactical situation.³²

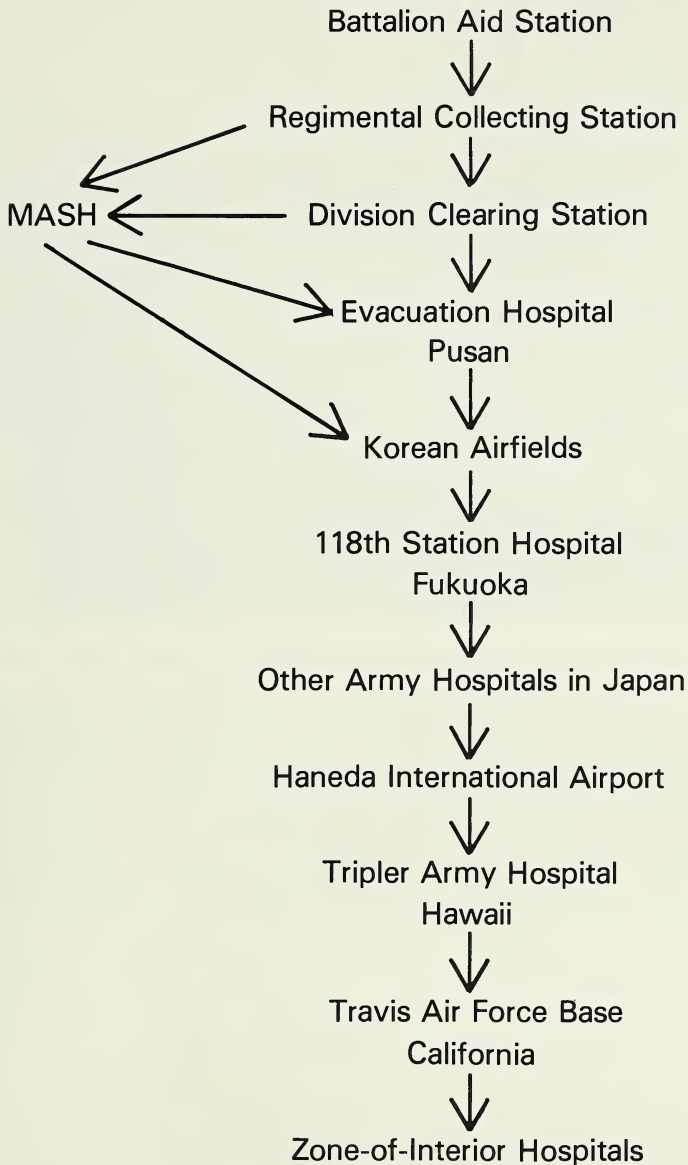
However they traveled, Pusan was the destination of all who were not airlifted directly to Japan or returned to duty from the forward hospitals (*Chart 1*). Here the major in-country hospital complex awaited them: the 8054th Evacuation Hospital, the Swedish Red Cross Hospital, the 1st Prisoner of War Field Hospital, plus the hospital ships and a growing array of special units. The commanding officer of the 52d Medical Battalion (Separate), attached to the 2d Logistical Command, acted as medical regulating officer, sorting the casualties and designating the hospitals to which each was to be sent. Evacuation from Pusan was carried out by air or sea to the 118th Station Hospital in Kyushu. Here patients were screened and either hospitalized or carried further to hospitals in Honshu.³³

Quickly outgrowing its original quarters in the Pusan Middle School, the 8054th Evacuation Hospital spread out to include two other schools plus a holding company. At one time this four-hundred-bed hospital actually had twelve hundred beds set up, though its complement remained twenty-four male officers and forty-one nurses. Its average daily admissions virtually doubled twice, from 108 in July to 204 in August, and again to 412 in September—over 12,000 admissions for that month, or about 10 patients for every bed even in terms of the hospital's maximum capacity. And this was not all. Some of the 8054th's personnel and equipment was tapped to organize the 1st Prisoner of War Field Hospital (Provisional), which quickly expanded to over four thou-

³²Medical Section, EUSAK, Summary of Activities for Period 25 June–13 July 1950, Encl 20 to EUSAK War Diary, RG 407, MMFB; EUSAK, Report of ETMD, November 1950, p. 5, file 350.05 (EUSAK) 1950, HRB. See also MFR, Hospitalization and Operations Branch, Medical Plans and Operations Division, OSG, 2 Aug 50, sub: Hospital Trains for Far East Command, file 322 (Hospital Trains); EUSAK, Report of ETMD, August–September 1950, file 350.05 (EUSAK) 1950; EUSAK, Annual Report of Medical Service Activities, 1950, pp. 6–8. All in HRB.

³³52d Medical Battalion (Separate), Annual Report of Medical Service Activities, 1950, sec. 1, file 319.1–2 (52d Medical Bn, Sep) Far East–1950, HRB. The chain of evacuation is discussed further in Chapters 7 and 8 of this volume.

CHART 1—MEDICAL EVACUATION, SEPTEMBER 1950



Source: Adapted from Warner F. Bowers, "Evacuating Wounded from Korea," *Army Information Digest* 5 (December 1950): 50. Though schematic and oversimplified, this sketch indicates some main lines of evacuation. Within Korea, movement was by road, rail, or air; between Korea and Japan, by air or sea; within Japan, by road, rail, or air; between Japan and the zone of interior, by air or sea.



U.N. PATIENTS IN A PUSAN HOSPITAL WARD, *formerly a school auditorium*

sand beds to provide care for both prisoner-of-war and U.N. patients. Only continuous evacuation enabled the 8054th to perform its function. Until September, when air service increased, evacuation to Japan was carried out mainly by water, with four vessels—the USS *Consolation*, USNS *Sgt. Andrew Miller*, HMHS *Maine*, and USNS *Sgt. George D. Keathley*—providing the backbone of the service. Yet several times the hospital's commander, Colonel Willis, was obliged to press into service ferry vessels, which were called "Red Ball" ships, to carry more evacuees. During July–September the hospital evacuated more than 15,000 patients.

Within its limitations, however, the 8054th Evacuation Hospital accomplished a near miracle, considering its origin and staffing. First organized on 1 July 1950 and staffed with personnel drawn from hospitals all over Japan, the 8054th had no opportunity to train as a unit. Yet this collection of officers and 124 enlisted men treated some 33,000 admissions during the last six months of 1950. The five operating tables were the scene of more than 6,000 surgical procedures; more than 5,000 enemy prisoners received treatment; and the death rate among U.N. patients was less than 1 percent. Both the numerical weakness of the Medical Service and its high professional competence were strikingly exhibited.³⁴

³⁴8054th Evacuation Hospital, Semimobile, Annual Report of Medical Service Activities, 1950, pp. 1–4, file 319.1–2 (8054th Evacuation Hospital, Smb1) Far East–1950, HRB.



FACILITIES AT THE 3D STATION HOSPITAL IN PUSAN

Particularly welcome because eight of its ten doctors were surgeons, the Swedish organization, though equipped as a four-hundred-bed evacuation hospital, functioned more like a rear-area MASH with expanded holding facilities. Between the time when it opened its doors on 25 September and the year's end, the hospital handled some 3,190 patients from thirteen nations, the majority either Americans or North Korean prisoners of war. By that time, the whole Pusan hospital complex had matured. Three hospital ships had taken up duties as "station hospitals afloat" off the coast and as ferries transporting the wounded to Japan. In addition, the 3d Station and 3d Field Hospitals were activated, the former using the personnel and equipment of the 8054th Evacuation Hospital and the latter that of the 1st Prisoner of War Field Hospital. Counting two hospitals briefly committed to Korea but withdrawn after the Chinese attack, thirteen hospitals, plus the ships, had served U.N. casualties at some time during the fighting of 1950, caring for more than 78,000 admissions.³⁵

The system had many advantages. The surgeon general preferred evacuation over local treatment whenever possible, in part because scarce specialists could

³⁵Quoted words from Plans and Operations Division, Medical Section, FEC, Daily Diary, 7 Sep 50, file Daily Diaries, 1950, Box 3146 (Medical Section, FEC, Day Files, 1950), RG 338, MMFB. See also 3d Station and 3d Field Hospitals, Annual Reports of Medical Service Activities, 1950, p. 1 and p. 5, respectively, files 319.1-2 (3d Station Hospital) and (3d Field Hospital) Far East-1950, HRB; USAFFE and EUSAR, "Logistics in the Korean Operations," vol. 3, pp. 18-20, 23, RG 319, MMHB; Swedish Red Cross Hospital, Annual Report of Medical Service Activities, 1950, file 319.1-2 (Swedish Red Cross Hospital) Far East-1950, HRB.

be more efficiently utilized in a few large treatment centers in Japan. There was also a political aspect to the system, for the Medical Service could avoid the World War II errors of having many idle or underemployed doctors in uniform, while the needs of civilian life were depleted. The effect in Korea, however, was to place a heavy burden upon the baker's dozen of installations there. As time progressed, holding capacity increased and statistics for the year showed that hospitals in Korea had returned about 50 percent of all casualties to duty without evacuation. Yet in many ways the hospitals throughout 1950 kept their early character as all-purpose medical turnstiles providing excellent emergency care and quick evacuation for all serious and many nonserious cases. To the future belonged specialized treatment centers and high-echelon care—in short, the emergence of a communications zone within Korea.

The Blood Program

For what was in essence a system of emergency medicine, one particular item of supply—fresh whole blood—was of paramount importance. The first response to the sudden need on the Korean battlefields came from Japan. Here, before the war, Tokyo and Osaka Army Hospitals had maintained small blood-banks to serve their own needs. Clearly, such sources could not meet the requirements of the fighting front as well. Hence, on 7 July the 406th Medical General Laboratory set up an organization that included a mobile collecting team, a collecting and processing center in Tokyo, and an advance blood depot in southern Japan. A courier service ensured delivery to Korea. During July almost 3,000 units were collected and about 1,600 shipped. American noncombatants and dependents supplied most of the blood. After 28 September Japanese volunteers also were accepted, though their blood was used only for injured Koreans. The first blood dispatched to Korea, in 70-pound refrigerated marmite cans, went to the 8055th MASH and the 8054th Evacuation Hospital.³⁶

In May 1950 the World War II blood and plasma program that had collapsed during the interwar years experienced a revival in the United States. The Red Cross maintained a system of blood banks, but only to supply civilian needs. Military hospitals, like those in Japan, secured donors to answer their own day-to-day requirements. No adequate stockpiles of plasma—which, unlike whole blood, could be kept for long periods—existed, and World War II stocks were nearing the end of their usefulness. With the onset of the emergency the surgeon general launched a program for collecting whole blood through the Red Cross, and the Department of Defense signed a contract with a biologics firm to

³⁶406th Medical General Laboratory, Report of ETMD, July 1950, p. 5; 406th Medical General Laboratory Activities Report, July 1950, file MDLB-406 (Activities Report, 406th Medical General Laboratory, Jul 50), Box 4717 (Nonorganic Units, MDSU-1 to MGGP-304, 1949-50), Entry 429, RG 407, MMFB; Milner, "Troubled Decade," ch. 5, p. 38; John M. Howard, ed., *Battle Casualties in Korea: Studies of the Surgical Team*, 4 vols. (Washington, D.C.: U.S. Army Medical Service Graduate School, Walter Reed Army Medical Center, 1955), 2:150-65. Japanese blood differs genetically from that of Western European peoples in the relative absence of the Rh-negative factor. A unit of blood is 500 cc and is roughly equal to a pint; each can held nine units. It is not clear from the sources whether technical considerations or covert racism caused the policy of segregating blood. See 406th Medical General Laboratory, Annual Report of Medical Service Activities, Professional Section (Annual Historical Report), 1950, pp. 155-58, file 319.1-2 (406th Medical General Laboratory) Far East-1950, HRB.



LOADING BLOOD IN A
HELICOPTER POD

process plasma. At first the Far East Command saw no need for whole blood from the zone of interior, but by mid-August, with the casualties of the Pusan Perimeter fighting crowding the hospitals, the command asked for large quantities. Red Cross collection for the military began that month, and about the end of August the first whole blood arrived in the command. By the end of 1950 the United States had delivered 21,188 pints from both civilian and military sources, while donors in Japan had provided 22,099. In this respect at least, the home front and rear areas were bleeding pretty freely for the sake of the fighting men.

A key to the high Korean survival rates among the wounded, whole blood was especially important during the critical first hours of treatment.

Most wounded men bled, and the con-

dition known as shock—with its characteristic marks of low blood pressure, chill, and rapid heartbeat—could rapidly become irreversible and end in death. To halt the circulatory failure that was a consequence of hemorrhage and the basic factor in shock, whole blood had no equal. The Far East Command originally estimated that each injured man would need less than a pint of whole blood (about 0.8), but battlefield experience steadily increased the amount to 3.3 pints. For a critically wounded soldier on the day of injury, a transfusion of 15 to 30 pints—up to three times his total blood volume—sometimes proved necessary. Transfusions maintained life even as hemorrhage continued; they stabilized the patient's condition, enabling the doctors to perform the necessary surgery. The rapid improvisation of a blood supply network that embraced varied donors—American servicemen, civilians, and Japanese—was fundamental to the survival of many thousands of wounded men.³⁸

The Growth of Psychiatric Support

The initial errors of evacuating nonpsychotics to Japan, installing them in comfortable hospitals, and allowing them to observe that those even more

³⁷406th Medical General Laboratory, Report of ETMD, September 1950, p. 8; Douglas B. Kendrick, *Blood Program in World War II*, Medical Department, United States Army (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1964), pp. 713–33; SG Conference Notes, 20 Oct 50, Medical Collection, HRB; Surgeon's Circular Letter 5, no. 12, Medical Section, FEC, 1 Dec 50, pp. 8–9, HRB; JLCOM, Annual Report of Medical Service Activities, 1950, p. 38, HRB.

³⁸Theodore C. Prentice et al., "Studies of Blood Volume and Transfusion Therapy in the Korean Battle Casualty," in *Recent Advances in Medicine and Surgery*, 1:163.

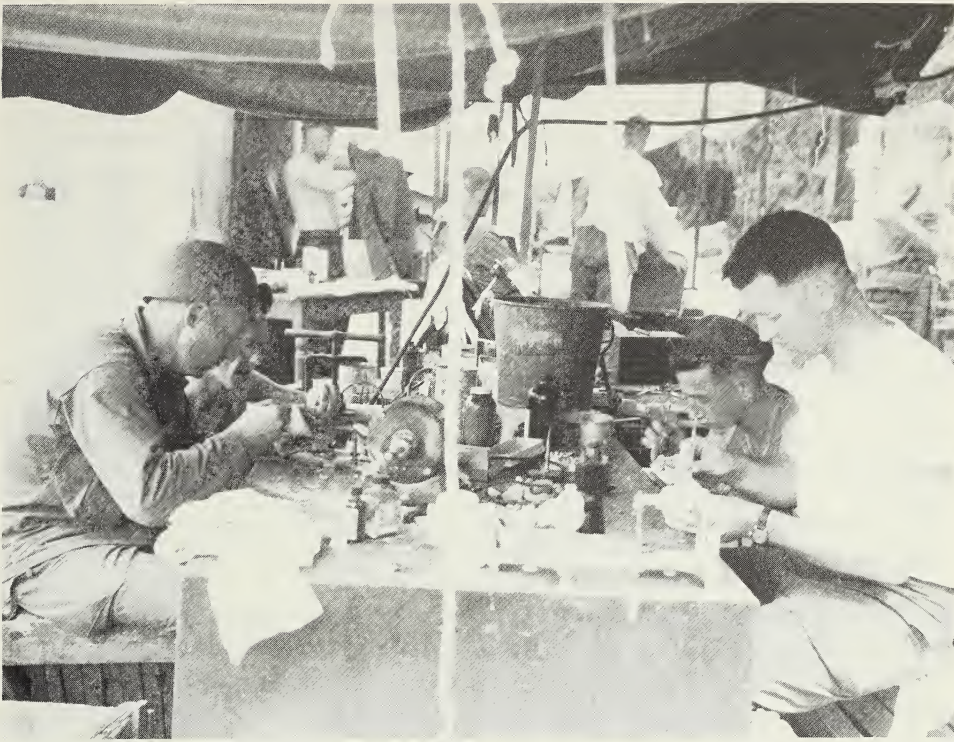
disturbed than themselves were rewarded with evacuation to the States demanding early attention. The record of combat psychiatry could easily justify pessimism about the ability of human beings to learn from experience. Less than five years after World War II, basic lessons already were forgotten or stored on a shelf, and the sudden demands of a new emergency required improvisation. Yet as the FEC psychiatric consultant emphasized, the system of psychiatric treatment that had taken two years to introduce during World War II was in operation within months in Korea. The presence of veteran officers was the key to the quick revival of proven methods. Individual, not institutional, memory made the achievement possible.

An interesting new development in handling stress was a morale-enhancing program of what might be termed preventive psychotherapy. World War II statistics showed that sharp increases in casualty rates of all types occurred when troops experienced combat for more than 180 days without relief. Hence, at the end of September the Department of the Army authorized temporary duty in Japan for the purpose of rest and recuperation (R&R). The Japan Logistical Command undertook the necessary logistical studies and, in October, presented a plan to the Far East Command for a five-day R&R period for personnel serving in Korea. The first combat soldiers to take part arrived on New Year's Eve. During the months that followed, the daily arrival rate increased from two hundred to five hundred and by the end of August 1951 some ninety-one thousand U.N. officers and men had enjoyed a furlough from the war. All in all, a sensible and in some ways unique program to relieve combat fatigue had taken shape in the command. Though astute commanders always had pulled individuals and units from the line in wartime for periods of rest, the Korean R&R program further systematized the practice. Utilizing the unique geography of the conflict, the Army encouraged its fighting men—somewhat as a swimmer gulps air—to taste the real world beyond the battlefield. Except for rotation, no more popular program came out of the war.³⁹

Dental Care

The dental service worked in a variety of settings, from advanced field units to the station and general hospitals of Japan. In forward areas dental officers with the medical battalions normally rotated through their divisions. In the 24th Division two dentists served with each of the 24th Medical Battalion's three clearing platoons during July, while the rest operated a clinic. Chaotic conditions made it "difficult to accomplish much dentistry." Here, as elsewhere, during times of crisis dentists assisted the medical officers. Once the Pusan Perimeter had formed, teams of dental officers visited the regiments to survey problems and treat patients who were in immediate need. In August, too, the division's Dental Section rigged a makeshift laboratory on a ¾-ton truck. Events began to take a more normal course. By the end of September a regular laboratory, housed in a 2½-ton truck, had arrived. Now dental clinics worked

³⁹Japan Logistical Command, "Logistical Problems and Their Solutions, 25 August 1950–31 August 1951," pp. 13–17, Ms no. 8–5.1A AE, RG 319, MMHB. For psychiatric treatment in the hospitals in Japan, see Chapter 9 of this volume.



DENTAL PROSTHETIC SECTION MAKING DENTURES *near the front lines*

out of vans either at the battalion headquarters or at the rear clearing station, which acted as a holding unit.⁴⁰

Similar accounts could be given of other battalions. In the 25th Infantry Division dental officers were assigned to each regimental combat team, sometimes serving as battalion surgeons to make up the deficit of physicians. Each clearing station had at least one dentist, and a central clinic worked at the battalion headquarters. A full prosthetic unit was set up in August. The same pattern—a central clinic with front-line service at regimental level—showed up in the 1st Cavalry Division. In all cases only emergency treatment was available during combat. In consequence the 7th Infantry Division found that at least three dental officers were needed for each regiment in a rest area, where soldiers had time to catch up on neglected problems and the dentists were at last free to practice dentistry.

Dentists were not assigned to the MASHs during 1950, though a few divisional dentists were attached—during October, for example, one from the 2d Division joined the 8076th MASH. Evacuation hospitals, however, had two dentists each. At the 8054th Evacuation Hospital in Pusan, two oral surgeons and one prosthodontist were assigned to the staff. An active clinic gave more than six thousand sittings, including among its patients American soldiers, U.N.

⁴⁰24th Medical Battalion, Annual Report of Medical Service Activities, 1950, Encl 4, Dental Section Report, file 319.1-2 (24th Medical Bn) Far East-1950, HRB.

troops, and POWs. In its familiar mingling of evacuation and station hospital duties the 8054th treated both evacuees passing through to Japan and local forces stationed around Pusan. Among the former, jaw fractures and maxillofacial injuries caused by gunshot wounds were common. The prosthetic section did work for men from the divisions whose own laboratories could not provide, among other items, the necessary bridges and false teeth. Field hospitals, by contrast, lacked dental laboratories. They depended on the divisions when within their areas, and otherwise did without.⁴¹

A distinctive feature of the dental officers' work was its variety. Quite apart from their professional specialty, they served as utility infielders for the Medical Service, taking on a melange of tasks. As dentists they carried out procedures ranging from the routine ones of filling cavities and extracting teeth to complex oral surgery of the wounded. As a rule, their work involved few life-threatening situations. Yet untreated dental problems could drastically diminish a soldier's efficiency, to say nothing of his personal comfort. In all respects, the contribution of Army dentists and their enlisted assistants was an important one.

Professional Services

As a repository of knowledge and a means of control the consultant system again proved its worth in Korea. Specialists from the Medical Service's own ranks staffed the consultants division at the Far East Command. They performed dual tasks in maintaining professional standards and ensuring proper assignment of replacements arriving in their own specialties. The consultant visited command hospitals, observed work in progress, and, without directly intervening or attempting to supplant the medical officer in charge, provided expert guidance and counseling. When new men arrived in the consultant's specialty (or, in the case of the nursing consultant, new women) he interviewed them; his recommendations were often equivalent to assignment. As regular officers, consultants sought not only to place men in the jobs best suited to them but also, by providing challenging assignments, to sell "the army to young doctors on duty in this theater." Consultants appear to have worked in full knowledge of the problems that had surfaced during World War II and with the will, if not always the means, to prevent their recurrence.⁴²

In choosing his civilian consultants, the surgeon general had similar motives. General Bliss told his staff on 19 July that

during the last war . . . he found an excess of doctors except where they were needed. He considers it most desirable that we have consultants, preferably civilians, going to those places who will see and know the difficulties. They can show the public that we are doing a good job or not. It would be very valuable to have intelligent men, top men, and as one part of their duty check on us and what we are doing. We could get the [support] of the American [medical] profession. They look on us now with the greatest of suspicion.⁴³

⁴¹8076th MASH, 121st and 8054th Evacuation Hospitals, Semimobile, and 64th Field Hospital, Annual Reports of Medical Service Activities, 1950, files 319.1-2 (MASH, 8076th Army Unit), (121st Evacuation Hospital, Smb), (8054th Evacuation Hospital, Smb), and (64th Field Hospital) Far East-1950, HRB.

⁴²FEC, Annual Report of Medical Service Activities, 1951, p. 16, HRB. The nursing consultant was Lt. Col. Alice M. Gritsavage of the Army Nurse Corps.

⁴³SG Conference Notes, 19 Jul 50, HRB.

Hence, the surgeon general yearly selected distinguished physicians for the triple task of providing professional guidance, bringing any misuse of doctors to his own attention, and serving the Army as ambassadors to the civilian profession.

Finally, teams of experts visited the Far East Command to deal with specific problems that had arisen in the field. A surgical team stayed from 26 November 1950 to 9 January 1951, providing instruction for medical officers on new techniques in antibiotic therapy, burn treatment, and the use of the intramedullary pin for mending breaks in the long bones of the body. A one-man "team" consisting of an anesthesiologist from Massachusetts General Hospital brought new studies in methadone, a morphine substitute then receiving its first trials, and a new compact field anesthesia machine. The malaria research team arrived in August, during the Pusan Perimeter battles, to test the effectiveness of the new antimalarial primaquine. In all, the first year of the war saw nine research teams operating in Korea, studying subjects that ranged from wound ballistics to DDT-resistant lice.⁴⁴

At the end of 1950 the Medical Service tallied its gains and losses in the conflict: six of its officers, including one nurse, killed; twenty-two missing in action; and eleven wounded. Its accomplishments had not gone unnoticed, General MacArthur declaring that in all his seventeen campaigns he had never seen better care.

Despite the roughness of conditions in Korea, the repeated crises occasioned by reverses in the field, and the shortages in trained medics and hospital units, the medical system that evolved during 1950 proved successful in its basic endeavor: saving the lives of the troops. The fatality rate of the wounded who were admitted to treatment was distorted by the rapid evacuation, but it was clearly lower than the 4.5 percent of World War II. Sharp questions would surface later about front-line evacuation, but none about the skill exhibited in the hospitals. The system of emergency care and quick evacuation that characterized the period, and the mix of veteran and tyro officers upon whom it depended, "saved the bacon" in a war an ill-prepared nation had not expected to fight. It shored up morale, especially in situations where the spirit of the American troops was fragile at best, and saved countless lives—an achievement beyond calculation.

⁴⁴Information on research teams in Medical Research and Development Board, OSG, History of the Korean Conflict, 25 Jun 50–8 Sep 51, pp. 1–10, file 314.7–2 (Army Medical Service Activities, 25 Jun 50–8 Sep 51), HRB.

CHAPTER 6

Field and Bunker

An early casualty of the winter fighting in Korea was the old system of divided commands. In late December the X Corps became part of the Eighth Army. General Walker, however, did not live to reap the benefits of a unified field army; on the twenty-second he died in a jeep accident. Yet a major innovation of Walker's—extending United Nations (U.N.) forces across the Korean peninsula from sea to sea—survived him. General MacArthur planned a fighting withdrawal to lengthen the Chinese lines of supply and a final defense, if necessary, in a new Pusan Perimeter. But Lt. Gen. Matthew B. Ridgway, Walker's successor, from the beginning focused his thoughts on attack. Until mid-January, however, retreat remained the order of the day.¹

The winter was harsh even by Korean standards. Temperatures rarely rose more than a few degrees above zero, and cold injuries were excessive. The 25th Infantry Division, which fought on the western coastal plain rather than in the even colder mountains of central and eastern Korea, recorded 684 cold injury cases in the first three months of the year, 319 of them in the all-black 24th Infantry. Equipment remained less than satisfactory. The shoepac still gave trouble, and infantrymen risked head wounds by throwing away their helmets, because no cap suitable for subzero weather would fit under the steel pot.

Disease seconded cold, for the Four Horsemen of the Apocalypse were in the saddle. During six months of war the movement of armies and refugees had broken down Korea's cellular structure of village communities. Millions living under great stress daily encountered strange pathogens, and epidemics flared like brushfires. Americans taking shelter in towns and farmhouses found civilians ill with smallpox and typhus. Infected towns were evacuated, their people dusted with DDT and booster shots given to the soldiers.²

In the last days of the old year, heavy attacks fell on the South Korean divisions holding the Imjin River line. U.N. forces retreated, first to the Han River, then farther south. For the second time the Chinese raised the North Korean flag over Seoul. But supplies faltered, and cold and disease thinned North Korean and Chinese ranks. On 15 January the 25th Division moved to

¹Except as otherwise noted, the tactical narrative for this part of the chapter is based on Mossman, *Ebb and Flow*, chs. 12–24.

²25th Infantry Division, Annual Report of Medical Service Activities, 1951, pp. 1, 7–8, file 319.1–2 (25th Inf Div) Far East–1951, HRB; Marshall, *Commentary on Infantry Operations*, p. 49.

the attack in the west. Other strikes followed along the U.N. line, and initial success rapidly turned a reconnaissance in force into a full-scale attack.

During February the enemy struck again, this time at the X Corps in central Korea and the Republic of Korea (ROK) Army as well, and won some ground only to run out of steam. In a late-winter thaw U.N. forces counterpunched in Operation KILLER, pushing forward over a landscape cut by rushing streams filled with ice. Subsequent advances brought them to the 38th Parallel. In March Seoul changed hands again for the fourth, and last, time in the war.

In two successive waves during late April and mid-May, the enemy's long-prepared and long-awaited spring offensive struck. U.N. forces, retreating slowly into prepared positions, drew the Chinese and North Koreans into intense fields of fire and inflicted enormous casualties—over 160,000 by American count. In the aftermath U.N. troops advanced to the extreme limits set by General Ridgway, who, as a result of President Truman's dismissal of General MacArthur, was now supreme commander in Tokyo. Under its third commander in six months, Lt. Gen. James A. Van Fleet, the Eighth Army now held essentially the positions that it would occupy until the end of the war.

On the Battlefield

Such a cut-and-thrust campaign compelled medics and their patients to encounter flying steel as well as cold and disease. Sometimes the danger came from friendly fire, as it did to a clearing platoon of the 24th Medical Battalion during January. A winter gale tore loose the panels identifying the unit to fliers, and Air Force planes strafed it, killing an enlisted man as he struggled to fasten the panels down again. But the chief danger came from hostile fire. The attacks of April struck the medics along with the line troops. Part of a collecting company serving the 5th Regimental Combat Team was caught in an ambush, losing seven men; a platoon of the 24th Medical Battalion lost six men including its dental officer. All were killed inside a dental van, where they were riding for warmth.

During the advance that followed the enemy debacle of May some Chinese units were bypassed when the advancing 24th and 7th Infantry Divisions met at Sinpori, North Korea. On 27 May Chinese soldiers trying to regain their own lines blundered into a terraced rice paddy where the Medical Company, 21st Infantry, had pitched its tents for the night. About 0200 guards, who were doubled because of the dangerous situation, challenged the intruders and opened fire. Shouting that they were South Korean soldiers to gain a momentary respite, the Chinese opened up with burp guns, killing a rifleman and a chaplain, Father Francis Xavier Coppens, who were drawn to the disturbance, like others in the medical company.

Quickly the firefight degenerated into a formless melee, for the night was profoundly dark and clouded and a heavy spring rain had begun to fall. The Chinese infiltrated the nearby regimental headquarters and fighting began around the command post. Firing and occasional grenade blasts continued



MEDIC TREATING WOUNDED CHINESE SOLDIER

through the hours of darkness. When dawn enabled the defenders to see the enemy, Pvt. Joseph Chisholm, who had been broken from sergeant only two weeks before, led a party that captured thirty prisoners. Other medical company personnel seized twenty-eight more, and medics and headquarters company personnel combined forces to capture a group of the enemy that had set up a roadblock nearby. About two dozen bodies of Chinese soldiers lay sprawled in the company area. The night's darkness and confusion had helped the lightly armed medics far more than they realized at the time, for in numbers and equipment the Chinese were incomparably stronger. Troops of the 5th Regimental Combat Team, arriving at daylight, began a roundup that bagged eleven hundred prisoners. Nonetheless, the medical company had done well for itself and its patients. In the aftermath the men were heard demanding, "Who in Hell says the medics can't fight?"³

Casualties were mainly victims of cold and combat, though injuries caused by accident were also common. Medics faced all the familiar problems of evacu-

³1st Lt. John Atkins, MSC, won the Silver Star and both companies received the Presidential Unit Citation for this action. See 24th Infantry Division, Annual Report of Medical Service Activities, 1951, p. 2, file 319.1-2 (24th Inf Div) Far East-1951, HRB; 3d Historical Detachment, "Medical Company Under Attack: Medical Company, 21st Infantry Regiment, 27 May 1951," Ms no. 8-5.1A BA 44, RG 319, MMHB. See also John F. Harris, "Practice of Field Medicine on Operation 'Killer,'" *Military Surgeon* 109 (December 1951): 683-88.

ating the injured and sick in a war of movement and in temperatures that sank on 7 January to -27°F. They also faced in a more severe form the old difficulty of evacuating from the mountains. U.S. forces had made forays into the mountains before, but the line now stretched across the peninsula, and the IX and X Corps lived, fought, and sought to move their wounded in some of the harshest country to be found in Korea's corrugated landscape. Medics hauled casualties over twisting roads that were steep and sheathed in ice and through narrow defiles that were deep in snow. The 2d Infantry Division surgeon, Lt. Col. Joel N. McNair, described some of his difficulties. Losses were high, as many as six hundred wounded reaching the medical companies in a single day and night. Doctors were too few, as were trained aidmen—many either killed, wounded, or captured during the December "bug-out." Long hauls exhausted the litterbearers. Riflemen had to be pressed into service, and the Medical Service Corps officers labored to teach them medical rudiments in spare moments when the flow of casualties slacked off. The ¾- and 2½-ton trucks had to replace ambulances lost in the retreat, though the vehicles were open and highly unsuitable for moving injured men in bitter cold.

By the time the major attacks took place in the spring, conditions had improved. The weather moderated, the new aidmen had learned their jobs, and in March nine Navy medical officers arrived to alleviate the doctor shortage. But the fighting brought a surge in the number of casualties, with monthly admissions to the clearing stations reaching 3,873 during May. Medical personnel and equipment suffered new losses. In the 38th Infantry two battalion aid stations with all their equipment and many of their personnel were lost in fighting around an enemy roadblock north of Hoengsong. Infantrymen ran into antitank and antipersonnel mines thickly strewn by the enemy to slow the advance, and massive injuries resulted. Traumatic amputations became common.⁴

Evacuation continued to depend primarily upon human muscle and increasingly battered wheeled vehicles. But the helicopter, now coming fully into its own, won praise from all surgeons. Everything seemed to increase its value—the harsh mountains, the bad roads, the constricted landing areas, the increasingly severe wounds. Even the cold weather seemed made for it, for rotor blades bit into heavy, frigid air better than into warm air, providing greater lift. ("It is much easier," said a pilot, "to take off with three people in the winter than with two in the summer.")⁵

Three medical helicopter units of four pilots and four mechanics each entered Korea in 1951. By early March the 2d Helicopter Detachment (soon to be renamed the Helicopter Detachment, 8191st Army Unit), with four machines, served the left of the line from its base at the 8055th MASH. The 3d Helicopter Detachment (later renamed the Helicopter Detachment, 8192d Army Unit), with three machines, was attached to the 8063d MASH; the 4th Helicopter

⁴2d Infantry Division, Annual Report of Medical Service Activities, 1951, pp. 1–2, 6, file 319.1–2 (2d Inf Div) Far East–1951, HRB; Paul T. Buerger, "Medical Support for Mountain Fighting in Korea," *Military Surgeon* 109 (December 1951): 694–700.

⁵8th Historical Detachment, "Helicopter Evacuation," p. 1, Ms. no. 8–5.1A BA 28, RG 319, MMHB.



LITTERBEARER COMING TO THE AID OF A CASUALTY

Detachment (later renamed the Helicopter Detachment, 8193d Army Unit), with four helicopters, to the 1st MASH. Over the course of the year the IX Corps moved fifteen hundred critical cases by helicopter, “and it is safe to say,” the corps surgeon reported, “that many lives were saved that would otherwise have been lost.”⁶ The helicopters were almost as important in what they moved forward as in the human load they brought back from the front. In the IX Corps they carried some five thousand pints of whole blood and a variety of urgently needed medical equipment as far forward as the battalion aid stations.

Among the pilots a mystique began to develop, an “intrepid spirit” that, accordingly to the 8076th MASH commander, “saved many many lives.”⁷ Separated from the crowd, working alone, and pushing their fragile craft ever closer to the enemy, such men came to resemble the pilots of World War I in their singularity and taste for derring-do. Though the helicopter’s course still lay from the collecting station to the MASH on normal runs, pickups from aid stations became common and some even occurred forward of the battalions. Early on, a

⁶IX Corps, Annual Report of Medical Service Activities, 1951, pp. 13–14, file 319.1–2 (IX Corps) Far East–1951, HRB. A 1st Helicopter Detachment was also set up, but machines and men were transferred to strengthen other units. In December 1952, after a ghostly existence of almost two years on paper, the outfit was abolished and replaced by the Helicopter Detachment, 8190th Army Unit.

⁷8076th MASH, Annual Report of Medical Service Activities, 1951, p. 12, file 319.1–2 (MASH, 8076th Army Unit) Far East–1951, HRB.

marked contrast showed between the rarity and value of the few available machines, which implied great prudence in their use, and the spirit of the men who flew them, urged on by the exigencies of war.

With the objective of making evacuation more responsive and quicker, the Eighth Army tapped corps surgeons instead of the Eighth Army surgeon to dispatch the medical helicopters. But calls from forward units still had to travel from headquarters to headquarters through poor communications lines, delaying the quick response that was supposedly the helicopter's trademark. Limitations in the performance of the Bell machines also showed up during early 1951. One corps surgeon concluded that the Bell, because it was small and maneuverable and could land and take off quickly in a small space, was useful in front-line service. But a machine to carry larger numbers of wounded for greater distances was necessary for evacuation farther from the line. He suggested the eight-place Sikorsky H-19, which the Air Force already used in more innovative ways than the Army was yet willing to contemplate. In March, for example, Air Force machines evacuated injured paratroopers from a drop at Munsan under mortar and small arms fire.⁸

Organization remained anomalous. The helicopter detachments belonged to the Eighth Army; were assigned to its Air Section; and, because of their medical mission, were attached to the MASHs. Despite these complications the detachments were, in every practical way, medical units, and successful ones at that. A contemporary study of the 8192d Army Unit gave a picture of such a detachment at work. The unit served the MASHs in the IX Corps area. The winter was a time of long hauls, for the front was too fluid for the MASHs to set up near the fighting line. Pilots carried extra gasoline in cans stowed in the litters, and at their destination points they refilled their tanks and strapped the empty cans into the pilot's compartment while the wounded were being loaded. In this way machines with a maximum range of 100 miles made round trips of up to 120 miles.

The ensuing months witnessed the stabilization of the front, which brought the MASHs forward and meant shorter hauls, and also a series of technical changes in the helicopters, which improved overall performance. The Hiller 23As of the 8192d Army Unit had engines that were too weak to lift two patients at one time. They also had Stokes litters; however, these wire baskets, which were standard in the Navy, proved to be unsuitable, especially for the seriously wounded who were difficult to lift into and out of them. At the recommendation of a pilot, Capt. Arne H. Eliasson, the Hillers were modified to take the conventional flat Army litters instead. In early July the 8192d received new helicopters with aluminum platforms equipped with plastic lids to protect the patient from the wind, and also Bell H-13Ds, with additional horsepower, to replace the Hillers.

Such changes improved the capacity of a device that was still experimental and operating far short of its true potential. Theory held that patients could not

⁸2d Infantry Division, Annual Report of Medical Service Activities, 1951, p. 2; I Corps, Annual Report of Medical Service Activities, 1951, p. 4, file 319.1-2 (I Corps) Far East-1951. Both in HRB. On Air Force rescue work, see Robert Frank Futrell, *The United States Air Force in Korea, 1950-1953* (New York: Duell, Sloan and Pearce, 1961), pp. 536-43.



CAPT. HUBERT D. GADDIS PILOTING A HELICOPTER *with two patients aboard*

be treated in flight—indeed, that they could not even receive intravenous fluids. The pilots, coming from other branches of the Army, had received no medical training. It remained for the pilots and the needs of the moment to show more of the helicopter's true worth. Actual operations violated every one of the general rules, undoing standard operating procedures and revealing wide capabilities. Some pilots devised field expedients to warm patients in flight by an improvised shroud over the engine manifold and to give transfusions in flight from bottles of plasma attached inside the cabins. 1st Lt. Joseph L. Bowler, an infantry officer flying with the 8191st Army Unit, worked with Lt. Col. James M. Brown, commander of the 8063d MASH, to perfect the device. With needles inserted into the patients' arms and plasma ready, the pilot could monitor the flow through plastic tubes to either of the two litter pods and, by means of a rubber bulb, could increase pressure in the bottle to regulate the flow. Later in the war Capt. Hubert D. Gaddis improved the device to permit administration of whole blood. The manufacturer adopted both expedients in turn for later-model Army helicopters.⁹

Similarly, general rules that pilots could neither fly at night nor bring their craft under fire made obvious sense when helicopters were so few, so fragile, and

⁹Capt Peter J. Dorland, MSC, "Army Air Ambulance Evacuation," ch. 2, pp. 24–25, in fldr 20, box 2 of *Dust Off* Background Materials, RG 319, WNRC.

lacked lighted instrument panels, and radios. But war did not always allow prudence to prevail. Like other pilots, Bowler flew at night in extreme emergencies, holding a flashlight between his legs, peering at his instruments through its flickering beam. Capt. Oscar N. Tibbetts of the Air Force, whose rescue detachment had launched the experiment with medical helicopters in Korea, won a Silver Star in March 1951 for a mission on behalf of his own service, which Army rules might have rendered impossible. During the Chinese attack he flew out of Sinanju over 80 miles of enemy-held territory to pick up a downed and injured F-51 pilot. An Air Force medic, T. Sgt. James Bryson, accompanied him. They found the pilot, loaded him aboard under small arms fire that damaged the tail cone of the helicopter, and got away. Tibbetts flew the last forty-five minutes of the trip in darkness without night-flying instruments. Army pilots also flew in under mortar rounds and descended on encircled units, rules or no rules. How else were they to do their jobs?¹⁰

Yet, derring-do or not, so few machines, their fliers and mechanics further burdened by parts shortages and difficulties in resupply, could not under existing circumstances be more than emergency vehicles in the most restricted sense. Despite hints of future potential the number of wounded moved by helicopters remained relatively small. In May—the premier month for the 8192d Army Unit during 1951—the detachment on its biggest day transported thirty-two patients on sixteen flights. A Bell, carrying two patients per trip, cost more than ten times as much as a ground ambulance that carried five, and helicopters had much higher maintenance costs and required more extensive (and expensive) training for both pilots and mechanics. Costly, experimental and cranky, the helicopter could be justified only on the grounds that those it carried, almost to a man, would have died without it.¹¹

The mission of the MASHs had not changed significantly. They remained Eighth Army units attached to one division or another for logistical support and court-martial jurisdiction only. Their distinctive Korean War form as small evacuation hospitals (two hundred beds) with medical as well as surgical functions endured. Larger than contemplated by the 1948 tables of organization and equipment, the MASHs were also less mobile. They still evacuated to the rear in a variety of ways: by helicopter in neurosurgical and some eye injury cases only; by railroad; or by fixed-wing aircraft direct to Japan. Their burden of casualties varied with the course of battle, averaging, in the case of the 1st MASH, fifty to sixty a day during the first four months of the year when parked ambulances had to be used as shelter for the “weary patients” because of the crowding. Intended to support one division each, they continued to support many. From 2 February until 23 April the 1st MASH typically treated the seriously wounded, injured, and ill of the 2d, 3d, and 7th Infantry Divisions and the 187th Regimental Combat Team. At no time did the MASH support fewer than three divisions.

¹⁰Surgeon's Circular Letter 6, no. 3, Medical Section, FEC, 1 Mar 51, pp. 52–53, file 461 (Circular Letters) FEC, HRB; 8th Historical Detachment, “Helicopter Evacuation,” p. 4, RG 319, MMHB.

¹¹8th Historical Detachment, “Helicopter Evacuation,” pp. 2–7; 8086th Army Unit, Military History Detachment, “Helicopters in Korea,” Ms no. 8–5.1A AJ. Both in RG 319, MMHB.

Field conditions, of course, prevailed throughout the period. The MASHs were now usually under canvas, for the war had destroyed almost all public buildings in the central Korean battleground. The enemy was often close. At Chechon the Chinese pushed to within a few miles of the 1st MASH, and "gunfire was easily heard." But because of the great number of patients and the condition of the roads the commander, Maj. Jesse F. Brown, refused to evacuate. Instead, the Chinese were driven back. In mid-April the MASH advanced to Chunchon. But the enemy spring offensive at Chunchon soon drove everyone back, and the hospital retreated to Wonju (*Map 4*). Later—renamed the 8209th MASH—the unit advanced to Hongchon where, as the most forward hospital, it cared for the wounded of X Corps during the Battle of the Soyang River.¹²

Men of several MASHs had to be detailed to guard duty, for the countryside was dangerous and infantrymen were unavailable for the task. Here an ironic reversal of roles occurred. Throughout American military history, line units had made a practice of detailing their least useful men to duty with the medics. In the 8076th MASH the most inept and least intelligent men were now detailed to guard duty, with predictably unsatisfactory results. Consequently, the hospital had to assign many of its best men to an additional task that the presence of guerillas and enemy stragglers from shattered units made impossible to shirk.¹³

The stories of the other MASHs were similar in outline, though in some cases their itineraries were more complex than those of the 8209th. Like the 8055th, the 8076th operated in nine locations between New Year's Day and the end of May, shifting from one corps to another to meet successive enemy attacks. What all MASHs had in common was a habit of being extremely busy. During the year the 8076th would admit 21,408 patients—1,048 during a single most active week in February, of whom 741 were battle casualties. Not only the sheer numbers but also the large proportion of wounded (47 percent overall) suggest a staggering burden on surgeons and nursing staff. A capacity of two hundred beds clearly meant little when, as happened in early January at Suwon, 130 new patients were admitted on an average day. As in 1950 the burden still lay upon the transport system to enable so few hospitals to work successfully in battles of such intensity.¹⁴

In addition to the four original MASHs, a fifth—called at first the 2d MASH but in May renamed the 8225th—arrived to lend a hand in the spring offensives. Organized at Fort Bragg, North Carolina, during November and December 1950, the unit was comprised of medical officers drawn from many duty stations (five were Navy surgeons) and enlisted men transferred from the 188th Medical Battalion (Separate) and the 82d Airborne Division. After training in the United States and Japan the hospital reached Korea on 28 March. It under-

¹²Quoted words from 1st MASH, Annual Report of Medical Service Activities, 1951, p. 2, file 319.1-2 (MASH, 1st Army Unit) Far East-1951, HRB. See also *ibid.*, p. 1, and 8209th MASH, Annual Report of Medical Service Activities, pp. 1-3, file (MASH, 8209th Army Unit) Far East-1951. Both in HRB. Technically, the MASH personnel and equipment were transferred to the new unit and the old one inactivated.

¹³8076th MASH, Annual Report of Medical Service Activities, 1951, pp. 4-5, HRB.

¹⁴*Ibid.*, pp. 2-3; 8055th MASH, Annual Report of Medical Service Activities, 1951, pp. 13-14, file 319.1-2 (MASH, 8055th Army Unit) Far East-1951. Both in HRB.



MAP 4

went the usual expansion and, by mid-April, was working at Hoengsong, under tents whose dirt floors were covered with sand or tarpaulins. Aided by an Air Force helicopter detachment, the new unit took over the four divisions previously handled by the 1st MASH, admitting almost 3,000 patients during May, two-thirds of whom were battle casualties. The success of the MASH in Korea was now beginning to result in the formation of new units, not only in the United States but abroad. A MASH organized and sent by the Norwegian government arrived in June and started work at Uijongbu on 9 July.¹⁵

Farther to the rear, the 121st Evacuation Hospital returned from Hungnam with the X Corps to a temporary station in the east coast town of Ulsan. The hospital quickly received its new mission: to take the overflow of patients from all the Eighth Army forward hospitals. A period of six months in the mud began for the 121st. Its first station was at Tuksong-dong, a town near Taejon, where its personnel worked in small buildings and lived in tents pitched in rice paddies, the only level ground available. Late in February the hospital advanced to Taejon, finding better quarters in a former station hospital built for U.S. forces during the Occupation.

With the general advance of U.N. forces under way, however, the 121st Evacuation Hospital moved again in early April to Seoul, where it supported only the I Corps. Here in a reprise of early days in Korea the hospital occupied a three-story school building, its dormitories, and a crowded tent city huddled beneath the walls. For a month in April and early May the Communist offensive drove it back to Taejon, but by the end of the month the hospital was working in the war-battered buildings of the Yongdung-po Industrial College in a western suburb of Seoul on the Kimpo peninsula. Amid a sea of mud an engineer platoon hammered together quonset huts to accommodate new personnel and patients as the bed strength rose from 400 to 750. Set at a major transport hub, the hospital handled all Eighth Army patients who were being evacuated to the south, or flown direct to Japan.¹⁶

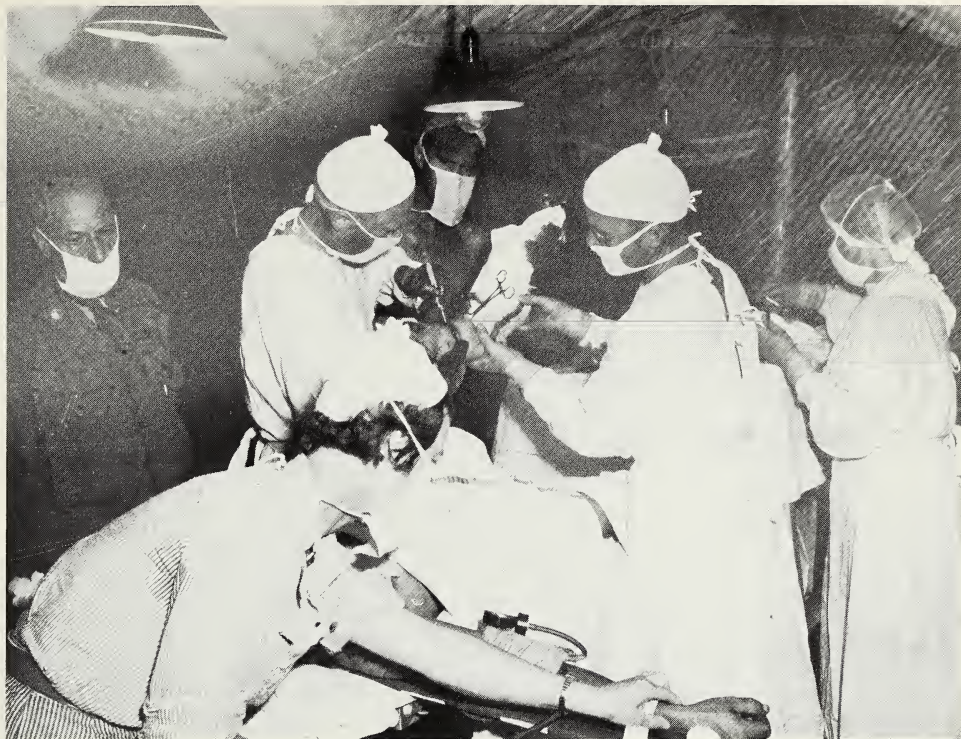
Life was rough during this period, work heavy, and amenities few. Some men regaled themselves too frequently with women of the villages, resulting in sixteen cases of venereal disease (VD). Other forms of recreation were virtually nil. Type B rations prevailed in the single mess where officers and men consumed the standard vienna sausage, luncheon meat, canned salmon, and other preparations supplied by the quartermaster. "The most unappetizing of these," reported the commander, "were the 'pork and gravy' and the 'beef and gravy'."¹⁷

In the wards and operating rooms work responded in barometric fashion to the fluctuations of battle and the shifting locations of the evacuation hospitals and the MASHs. During 1951 nearly 46,000 admissions flooded the 121st Evacuation Hospital. Concealed in the average of 126 per day, however, were

¹⁵8225th MASH, Annual Report of Medical Service Activities, 1951, pp. 1-3, file 319.1-2 (MASH, 8225th Army Unit) Far East-1951, HRB; 8086th Army Unit, Military History Detachment, "Surgical Hospital in Korea," Ms no. 8-5.1A DN, RG 319, MMHB.

¹⁶121st Evacuation Hospital, Semimobile, Annual Report of Medical Service Activities, 1951, pp. 1-2, file 319.1-2 (121st Evacuation Hospital, Smb) Far East-1951, HRB. All information on this hospital is from this report.

¹⁷Ibid., p. 7, HRB.



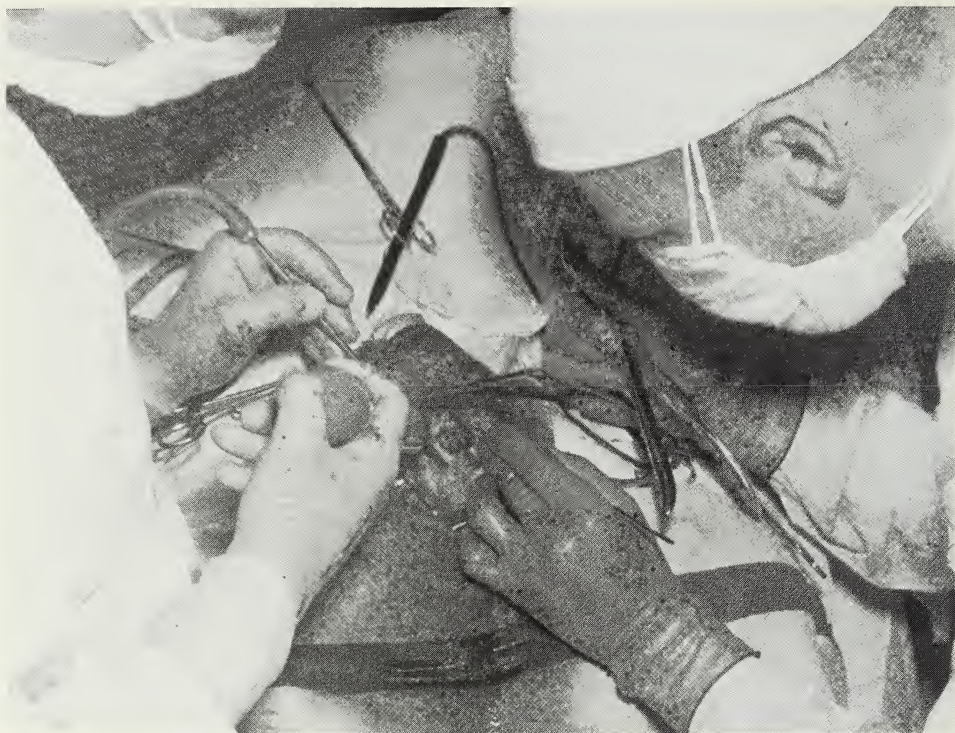
NORWEGIAN MASH SURGEON AMPUTATING AN ARM

drastic quantitative and qualitative changes. Admissions ranged from none on some days to more than 600 on others. Surgical patients—usually the ones needing the greatest care—were few or many in number, according to the current state of the fighting. Their wounds were mainly peripheral, provided the MASHs were operating normally and intercepting the abdominal and chest cases. Only when the MASHs were unusually far behind the fighting, or were on the road and unable to receive patients, would they shunt the more serious cases to the evacuation hospitals.

The location of the 121st Evacuation Hospital—forward at Yongdung-po or far to the rear at Taejon—also had a visible effect on the number of battle casualties. Surgical cases crested in June, outrunning the medical by more than 600 and then falling behind as the intensity of the fighting dropped off. By midsummer evacuees were fewer, local cases more. Medical problems, notably hepatitis and hemorrhagic fever, gained at the expense of the surgical and sometimes required as much nursing as the most difficult battle wounds. In the intervals between battles the 121st found itself changing willy-nilly into something that resembled a large station hospital for the Seoul-Inchon area.¹⁸

Despite mud, movement, field conditions, and the staggering patient load, some notable clinical advances highlighted the spring months. A urologist

¹⁸Hemorrhagic fever is treated at some length later on in this chapter.



NEUROSURGICAL TEAM AT THE 121ST EVACUATION HOSPITAL *performing a brain operation*

joined the staff, not so much to perform traumatic surgery—though missile wounds of the genitourinary system did occur—but to provide at an advanced location regular treatment of lesser problems that were distressing to the patient and an obstacle to performance of duty. Bladder inflammation and problem cases of venereal disease were common. The genitourinary unit did cystoscopies and performed some circumcisions. Urological work varied inversely with battle wounds, the unit serving as part of the surgical service when battlefield admissions were high. During lulls men found opportunity to seek care for lesser problems, or were referred by dispensaries, in either case finding themselves stretched out on the cystoscopic table that an operating room technician had contrived out of wood and scrap metal.

The most important surgical innovation was the Eighth Army's organization on 25 April of the 1st Provisional Neurosurgical Detachment. The new unit was assigned to the 52d Medical Battalion and attached to the 121st Evacuation Hospital. The treatment of neurosurgical cases was problematic from the outset of the war, for in no form of injury was quick action more important than in wounds of the brain and spinal cord. Yet the shortage of specialists initially precluded such work in Korea, except under emergency conditions, and brought undesirable delays even in Japan. The new unit of two neurosurgeons, two nurses, and four enlisted men under Capt. Griffith R. Harsh was designed as an

experimental answer to a persistent failing, and it proved to be a successful one. For a time the able but abrasive neurosurgical consultant of the Far East Command, Lt. Col. Arnold M. Meirowsky, spent half of each month working with the new unit. Until mid-October, when Meirowsky set up and headed a second detachment at the 8209th MASH, the one at the 121st Evacuation Hospital performed the only neurosurgery available to U.N. forces in Korea.¹⁹

Besides the skill of the specialists, other elements dovetailed to make the neurosurgical venture a success. At Yongdung-po the hospital received patients from all three corps areas and evacuated them through airfields that lay close at hand. The 121st Evacuation Hospital offered the convenience of a permanent neurosurgical operating room stocked with a variety of useful equipment, including adjustable beds and stryker frames for holding and turning patients with spinal cord injuries. By the end of July the neurosurgical detachment at the 121st had performed 331 operations with an operative mortality rate of 8.5 percent, a significant improvement over the 11–15 percent common in World War II.

In sum, a specialized channel now existed for such casualties, running from aid station by helicopter to the neurosurgical team, by helicopter again to an airport, and by an Air Force C-54 direct to Tokyo. The wheeled ambulance was eliminated, as were stop-offs in hospitals not specially equipped. This total system, rather than the neurosurgical team alone, made the Korean War a milestone in the management of such injuries in the field.²⁰

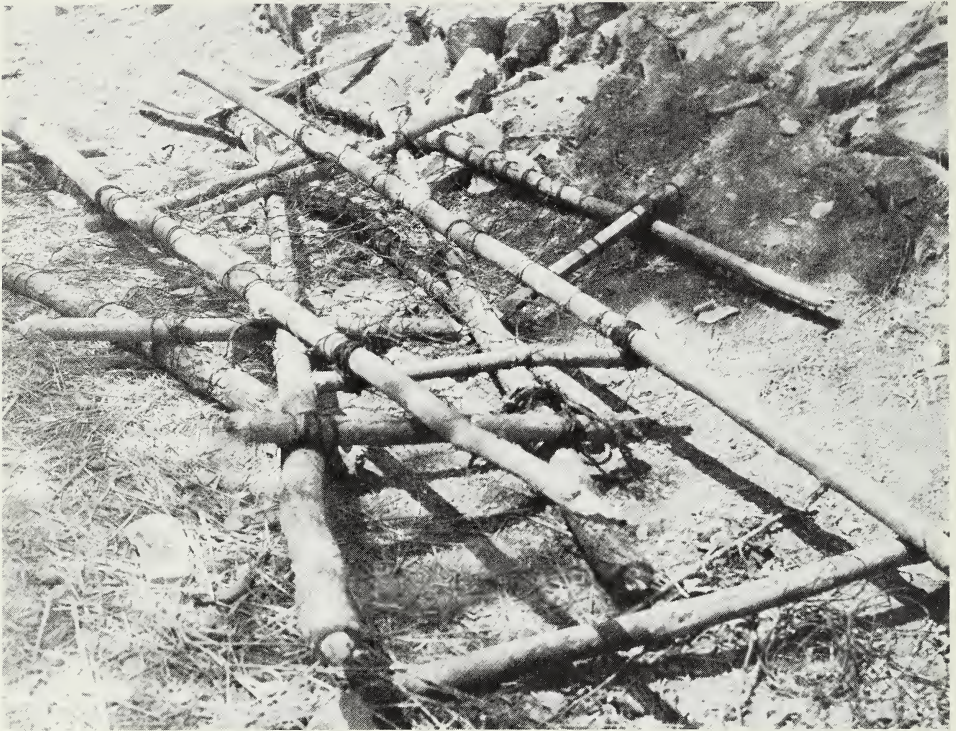
And yet, despite important innovations, the first half of 1951 was primarily a time of basic field medicine in Korea's forward hospitals. Medics were obliged, like the Red Queen in *Through the Looking-Glass*, to run as fast as possible in order to stand still. Their improvements were only seeds that would flower in the coming period of static warfare. So long as the armies were on the move, the medics' main task was simply to keep up.

The Third Horseman

The third of the traditional Four Horsemen of the Apocalypse was disease, and the first half of 1951 saw epidemic illness at its worst in war-wracked Korea. No part of the peninsula and none of those who lived and fought there were entirely immune to its dangers, though U.N. soldiers were almost certainly the healthiest single group because of the rigorous medical discipline under which they lived. Contagious hepatitis continued as a severe problem, but the

¹⁹On the makeup of Meirowsky's detachment, see 8086th Army Unit, "Surgical Hospital in Korea," p. 26, RG 319, MMHB. Meirowsky was not a favorite with his colleagues, some of whom called him the "Mad Russian." See Interv, Samuel Milner with Col Harry L. Berman, MC, n.d., AMEDD Oral History file (Berman), HRB.

²⁰U.S. Army Medical Service, *Neurological Surgery of Trauma*, ed. Arnold M. Meirowsky (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1965), p. 18; Far East Command and United States Army Forces, Far East (hereinafter cited as FEC and USAFFE), Annual Report of Medical Service Activities, 1952, pp. 39–40, file 319.1–2 (FEC) Far East–1952, HRB.



PRIMITIVE STRETCHERS USED BY CHINESE MEDICS

threat that epidemics already afflicting civilians and enemy troops might spread was even more alarming.

In South Korea the United Nations Command struggled to suppress outbreaks among civilians and prisoners of war (POWs) with mass inoculations and heavy applications of DDT to individuals and (by aerial spraying) to the environment at large. Medical aid flowed in through several channels, American and international, with the United Nations Civil Assistance Command, Korea, allocating funds, equipment, and manpower. In North Korea health conditions were at least as bad and far more difficult to deal with, because China's medical capability was almost as slight as North Korea's and because direct Russian intervention was limited by several factors, including the need to avoid direct confrontation with the United States.

Hence, the picture of the enemy's health that United Nations Command technical intelligence officers pieced together was a dark one. Disease was rampant among North Korean civilians and the troops of both Communist allies. A high incidence of typhus appeared among the soldiers; only about a fifth of the North Korean fighting men had received inoculations, and the Chinese, though given shots before they were sent to Korea, were not reimmunized until July 1951. Additionally, effective antibiotics were lacking to use against typhus if it did occur. Relapsing fever and malaria were also common in early 1951, as the diseases of winter overlapped those of spring. In one enemy unit Chinese medics

reported that typhoid and “recurrent fever” were spreading among both soldiers and civilians. Not surprisingly, with the medical facilities of the country now controlled by the military, the civilian population appeared to be in even worse condition than the soldiers. In the disrupted central provinces, where fighting continued into midsummer, outbreaks of typhus were widespread. Agents in North Korea reported plague near Wonsan, bringing MacArthur’s chief of public health and welfare on a risky expedition behind enemy lines.²¹

On 25 February a radio report from an agent in the Wonsan area described enemy soldiers who were dying of a disease characterized by high fever, backache, headache, and running sores. Though bubonic plague had not attacked Korea since 1912, it was endemic in Manchuria, where, as in the western United States, a reservoir existed among wild rodents. If the Chinese inadvertently had brought the disease with them, a serious danger loomed for U.N. troops who were not immunized against it. Because the immunity lasted only three to four months, inoculations against plague normally were not given and large stocks of vaccine were not maintained. Adding to the danger was the main road and rail route that ran south from coastal Wonsan to the front lines, which made contact between infected enemy soldiers and U.N. fighting men only too easy. Because the plague could assume the pneumonic form and could spread like influenza by droplet infection, with almost 100-percent mortality, ascertaining whether or not the Black Death was afoot in Korea became a matter of first priority for MacArthur’s headquarters.

As the public health and welfare chief, Brig. Gen. Crawford F. Sams led a party of three to Wonsan to make the determination. With him were Lt. Eugene F. Clark of the American Navy, Lt. Comdr. Youn Joung of the ROK Navy, and an interpreter. The Navy placed at Sams’ disposal a landing craft, LCIL-1091, fitted up as a floating laboratory to aid in epidemic control. By noon on 9 March the craft was moving in choppy seas through the minefields of Wonsan harbor under escort of a frigate, the USS *Sausalito*, which was part of the squadron blockading the port. A waiting game ensued as Sams attempted to get ashore without falling into the hands of the Chinese and North Koreans, whose record in trapping agents was a good one. He hoped to get access to one of the villages used as hospitals by the Chinese, who drove out the inhabitants and filled the houses with their own sick and injured. Here, if he had any doubt of the

²¹Conditions in South Korea are treated in Chapter 10 of this volume. On North Korean conditions, see Rpts, Capt Ralph M. Takami, MC, Medical Intelligence Officer, Medical Section, FEC, 30 Jun 51, subs: The Present Status of the Medical Service in the Chinese Communist Forces and The Present Status of the Medical Service in the North Korean Army, file 350.09 (Intelligence), Box 3129 (Medical Section, FEC, General Records, 1951), RG 338, MMFB. See also, by the same officer, copy of Rpt, 31 Jan 51, sub: The Enemy Winter Health Potential, HSF (Takami-1952), HRB, and Rpt, 31 Dec 51, sub: Disease Incidence in Enemy Troops, Encl to DF, W. E. S. [William E. Shambora], Medical Section, FEC, to G-2, FEC, Attn.: Maj Lovelace, 11 Jan 52, sub: Medical Intelligence, file 350.09 (Intelligence), Box 3087 (Medical Section, FEC, Decimal File, 1952), RG 338, MMFB; Chinese Medical Rpt, 8 Mar 51, in Military Intelligence Section, General Headquarters, Far East Command, *Operations of the Military Intelligence Section, GHQ, SWPA/FEC/SCAP, Supplement: Korea, 1950-1951*, vol. 3, Intelligence Series, ch. 8, insert 37, item 26 (202487), pp. 121-22, LIB. On conditions in the Chinese forces, see also Goulden, *Korea*, pp. 462-67. According to Goulden, the Central Intelligence Agency caused a shipload of medical supplies destined for North Korea to be pirated, worsening the enemy’s situation.

diagnosis, he “intended to knock out one of these men, and, if necessary, kill him, to get him out of the building where we could whack off a finger or take some smears from these so-called running sores—couldn’t very well lug a body around and drag it out to this ship, the way some people thought we were going to do.”²²

For a time, based on an offshore island, Sams interrogated agents from the mainland but found their stories contradictory. At other times, from the deck of the destroyer *Wallace L. Lind* he watched “some fine shooting,” as naval guns set villages afire with white phosphorus and battered enemy gun positions along the beach. On the evening of 13 March Sams and his party at last were able to embark on a whaleboat towing a rubber raft. In growing darkness and chill wind they watched the lights of Chinese vehicles moving along a road that paralleled the beach. Ashore they met three agents, tough-looking characters armed with carbines, an M1, and a Russian burp gun. Among them was the man who had made the initial report.

The agent turned out to be a man of education, a chemist who had worked in the oil refinery at Wonsan before the war. On orders to determine the disease situation among enemy troops, he had joined one of the parties of peasants carrying sick soldiers to a nearby health resort where the Chinese had set up a hospital for communicable diseases. Here he observed about fifteen hundred cases of smallpox and typhus, plus the suspected plague victims. Under close questioning he described their precise appearance, including the eruptions on the arms, legs, and torso that gave Sams the answer he had sought. The disease could only be smallpox in its hemorrhagic form. The confusion with plague stemmed from a misassociation; the bodies became black at death, because of subcutaneous bleeding, and the Korean phrase for plague was *huksa byung* (“black pest”). So precise was the account that Sams decided against making an effort to obtain blood from a victim for testing on the laboratory ship, and plans to kidnap a patient, if necessary, also were abandoned. Sams returned to the waiting ship through rough surf and thence to Sasebo with information that enabled the United Nations Command to put aside for the present any campaign against plague in Korea.²³

On the whole, the United Nations Command was lucky as well as efficient in its efforts to control epidemic disease. Though beset by cold injury, hepatitis, and respiratory ills, its forces were incomparably healthier and better fed than their opponents. Evidence is lacking to assess the impact of disease on the course of battle. But a combination of three factors—difficulties of supply, the savage weather, and the reduced physical efficiency of the fighting men—formed a serious obstacle for the Communists in their attempts either to

²²Presentation, Brig Gen Crawford F. Sams, MC, Washington, D.C., 8 Jun 51, file 352 (Korea) F, 1951, Box 53, Accession no. 56A-179, RG 112, WNRC. Quotation in the following paragraph is also from this source.

²³Rpt, Brig Gen Crawford F. Sams, MC, Chief, Public Health and Welfare Section, SCAP, to Chief of Staff, FEC, 17 Mar 51, sub: Special Operations in North Korea, file Special Operations in North Korea—General Sams, Box 3179 (Public Health and Welfare, Medical Section, FEC, Korea—Reports to Korea—Sanitation), RG 338, MMFB. See also Sams’ account in his manuscript autobiography, “Medic,” 2:707–20, LIB. Sams received the Distinguished Service Cross for his action.

take advantage of their initiative in January or to resist the U.N. counterthrusts later on. Perhaps the best estimate is that these factors delayed the Communist spring assaults, allowing crucial time for Ridgway to infuse new confidence into his dispirited army.

Chinese and North Korean charges that Americans were conducting germ warfare—then beginning to be heard—had no basis in fact. But there is little doubt that the natural disease environment of Korea, all its effects worsened by war, fought primarily for the best immunized, best cared for, best nourished troops. Disease was not a weapon of the U.N. forces, but it was an ally.²⁴

Into the Bunkers

June found the fortunes of the Communists at a low ebb. Famine conditions and heavy losses had disordered their armies. Epidemics of the winter lingered and overlapped those of the spring, as malaria joined other ills afflicting their long-suffering troops. Chinese stores of vaccine at home were confiscated to aid the fighting forces, and medical supplies had begun to arrive from the Soviet Union and other Communist nations, but the effects as yet were small. In May the North Korean Army inoculated 90 percent of its men with a formidable Russian polyvaccine called Nisin Baktin. The vaccine was supposed to protect against six major diseases but, by one account, had such violent side effects as almost to constitute a disease in itself. A widespread but sporadic effort to immunize both soldiers and civilians, and even POWs, was under way by midsummer, but the Communists did not launch a major program to contain the chaotic disease situation until late summer and fall.

Against an enemy depleted in numbers, in stamina, and in morale, U.N. troops advanced through eastern North Korea and halted along a defensible line chosen by General Ridgway. American reluctance to commit more resources to the conflict in Korea and the Communist setbacks of January–June 1951 created conditions in which a compromise settlement of the war became possible.²⁵

Even if not the hoped-for road to peace, a new phase of the struggle began on 8 July. Representatives of both sides met at the North Korean town of Kaesong to arrange for the first negotiating session, which they agreed was to take place two days later. While the peace talks started on what was to prove a long and acrimonious course, the Joint Chiefs of Staff adopted a strategy based on the assumption that U.S. forces must remain in Korea and exert pressure on the enemy to “encourage him to negotiate.”²⁶ Systematic air strikes against enemy communications and daily patrol activity along the line helped to define the nature of the new war. The Chinese and North Koreans seized upon the lull to

²⁴Germ warfare charges are treated in Chapter 7 of this volume, and information on the treatment of hepatitis may be found in Chapter 8. On the probable impact of disease and supply problems on the Communist forces, see Presentation, Sams, 8 Jun 51, RG 112, WNRC.

²⁵Except as otherwise noted, the general narrative of the period that follows is based upon Walter G. Hermes, *Truce Tent and Fighting Front*, United States Army in the Korean War (Washington, D.C.: Office of the Chief of Military History, Department of the Army, 1966). On the effects of Nisin Baktin, see Deane, *I Was a Captive in Korea*, pp. 170–71.

²⁶Hermes, *Truce Tent and Fighting Front*, p. 58.



BUNKER-TYPE FORWARD AID STATION, *showing log construction of roof and walls*

move supplies forward and build up their forces. U.N. fighting men dug in along the main line of defense, code-named KANSAS, and the outpost line, code-named WYOMING, that screened the western sector of KANSAS.

By 1 July, after energetic digging and building, KANSAS resembled the fortified Western Front of World War I. Sandbagged bunkers, strengthened with log walls and roofs and connected by trenches, housed automatic rifles and machine guns. Shrubbery and camouflage nets concealed mortar and artillery positions. Mines and barbed wire fronted the line in cleared fields of fire, except where WYOMING screened KANSAS. In the bunkers fighting men became housekeepers, ingeniously scrounging or building the amenities that could give a measure of comfort to their situation, or at least make it more endurable—flooring, furniture, cots. Patrol bases forward of the main line of resistance drew enemy attacks but provided depth to the line and made surprise less likely. Continuous patrolling and intermittent fierce battles for strongpoints shaped the course of the fighting.

The first of these battles developed around a valley near Mundung-ni in eastern Korea, which journalists named the Punchbowl. General Van Fleet, hoping to straighten his line, forestall enemy attacks, and restore the fighting edge of his troops, ordered the capture of the western heights overlooking the

Punchbowl—Heartbreak Ridge and Bloody Ridge. Here, late in August, ROK Army forces moved to the attack, soon to be followed by a major push of X Corps against tenacious enemy defense. Bloody Ridge fell in August; fighting then began on Heartbreak, a narrow ridgeline with three main hills and spurs arching east and west that caused a viewer to compare it to the “spinal column of a fish, with hundreds of vertebrae.” Here desperate fighting developed in terrain so harsh and swept by enemy fire that litterbearers sometimes took ten hours to haul a casualty down from the forward 23d Infantry of the 2d Division. Costs were heavy. The allies sustained twenty-seven hundred casualties at Bloody Ridge, the 2d Division alone some thirty-seven hundred at Heartbreak Ridge. Similar losses followed offensives further west in which the 1st Cavalry Division lost 2,900 men.²⁷

Typical of the medics’ battle experience was that of the 1st Cavalry Division’s 15th Medical Battalion during the October campaign. Operation COMMANDO, as the I Corps advance was dubbed, entailed savage fighting on the division front where defenses like those the North Koreans had dug into Heartbreak Ridge awaited—“strong bunkers supporting each other with automatic weapons fire, and . . . heavy concentrations of artillery and mortars interdicting the approach routes to the hills and ridges.”²⁸ Under Maj. Robert C. MacDuffee of the Medical Corps, the battalion located one clearing platoon, its medical supply, and the ambulance company headquarters at Yonchon, a town on the railroad line that led north toward the Iron Triangle (Pyongyang-Kumhwa-Chorwon). Another clearing platoon set up a holding station down the railroad line at Tongduchan-ni, and the third platoon with the remainder of the battalion lay still further to the rear at Chongong-ni. Farthest forward were the ambulance platoons, which were attached to the regimental collecting stations but often evacuated from battalion aid stations when litter jeeps were unable to handle the load of wounded. Drivers worked around the clock, sometimes under fire; their machines clocked over 5,000 miles in the eighteen days of fighting. On one occasion maintenance men worked on three shell-damaged vehicles at night in a blacked-out tent and had them back on the road at 0200. Helicopters got maximum use, with first preference given to patients who had head injuries. On one afternoon (3 October) there were 20 flights; sometimes three aircraft were loading at one time. In all, 110 patients were carried in this way during the battle.

More important numerically were two rail buses that used tracks to bring the seriously wounded back to the 8055th MASH. The buses worked at night, when helicopters could not fly, were smooth and rapid in movement, carried more than twice as many men (250 in all), and allowed transfusions and other treatment to be given en route. Yet like the other vehicles they were subject to breakdowns, and delays in service of up to two days occurred when they were

²⁷Quoted words from *ibid.*, p. 88; see also pp. 90 and 96. For an extended account, see 2d, 3d, 4th, and 8th Historical Detachments, “Action on ‘Heartbreak Ridge,’” especially pp. 17 and 34, Ms no. 8-5.1A BA 55, RG 319, MMHB.

²⁸Hermes, *Truce Tent and Fighting Front*, p. 99.



EVACUATION BY TANK DURING THE OCTOBER 1951 FIGHTING

sidelined. Hospital trains came as far forward as Yonchon, hauling out some 900 patients during the battle, most to the 121st Evacuation Hospital to avoid the overcrowded MASHs. In the Yonchon railroad yards medics set up a mobile kitchen and served full meals to all the wounded who were not headed for immediate surgery at the MASHs. Medics fed litter patients—those who could walk hobbled to tables—and, as time permitted, scrubbed some of the grime off the wounded in hasty baths.

Division medics complained that the 8055th MASH was located too far to the rear (25 miles) and that the Norwegian MASH, though a little closer to the fighting line at 20 miles, was too small to absorb many patients. Lengthy hauls, mechanical failures, and heavy casualties gave greater importance to an increased emphasis on holding patients within the division. Small holding sections were set up at regimental collecting stations, and one clearing platoon provided a holding station at division level as well. The aim was, of course, to keep minor wounds, injuries, and illnesses out of the crowded evacuation channels and to avoid needless personnel losses. Another advantage of the system was that it sopped up neuropsychiatric cases. Prolonged close combat, without food or rest, brought its usual crop of stress and fatigue victims. Mild cases never left their regiments. A total of 265 more severe cases reached the rear of the 1st Cavalry Division medical chain at Chongong-ni, where they got baths, clean clothes, and plentiful food in four meals a day. After two to five days of



ROAD-RAIL BUS, *with flanged wheels raised*

rest, 170 (65 percent) returned to duty, and the rest were evacuated. The time was not far distant when the Eighth Army's entire system would adapt to the new conditions of war along lines suggested by the division's experience. Regimental and division medics would do more basic surgery and hold more patients; MASHs would move closer to the line.

Despite difficulties, the evacuation and treatment system seems to have done its job. One persistent problem that had afflicted all the Korean operations in 1950 reappeared in local form as blankets and litters piled up at the MASH and vanished from the forward elements. But even when the system failed the people succeeded. Rotation by this time was working well, sometimes too well, and new personnel had come en masse into the division during the late summer. Despite their inexperience most reportedly adapted to the difficult conditions and did well in their baptism of fire.²⁹

The 1951 fighting also found the non-American U.N. forces fully deployed in Korea. Totaling 36,200 men at the end of March, this category was comprised of allied units from many countries: Great Britain and Australia, whose men had arrived in the summer of 1950; Turkey, Canada, New Zealand, Thailand, Holland, France, and Greece, whose men had followed before the end of the

²⁹1st Cavalry Division, Annual Report of Medical Service Activities, 1951, Encl 1, After Action Report—Operation COMMANDO, pp. 1–5, file 319.1–2 (1st Cav Div) Far East–1951, HRB.

year; and Belgium, Ethiopia, Colombia, South Africa, and the Philippines, whose men joined the effort in 1951. Sweden and India each had sent a field medical unit in late 1950, as did Norway the following year.

At first all foreign forces were attached to larger American units, which handled their supply and evacuation needs while integrating them tactically. In July 1951, however, the various forces of the British Commonwealth formed the 1st Commonwealth Division. The British already had an autonomous medical supply system that served their units up to the level of the MASH, at which point their casualties entered the American chain of evacuation. The seriously wounded, on reaching Japan, often were shunted to the British Command of Forces hospital in Kure. More typical were the Greeks, who—despite the presence of their own doctors, dentists, litterbearers, and aidmen—sent their wounded through U.S. channels; the French and Dutch, who had their own medical personnel for front-line units as far back as the aid stations; and the Ethiopians, whose German-trained European surgeon, sixteen aidmen, and two litter jeeps cared for the battalion's needs but then evacuated through the American chain.

Other problems were slight. Language difficulties proved less serious than expected, despite the paucity of translators and the general American incompetence with foreign languages. The fact that many foreigners spoke at least a small amount of English helped; so did the presence of American advisers with the Turks and the British background of some other Third World forces. In many cases doctors were obliged to rely on objective clinical signs, rather than questioning the patient. This technique worked out well in surgical cases where the injury was usually evident but less so in medical cases where a sick man could only point to his pain and use sign language to explain it. In the view of American medics, doctors with the U.N. forces ranged in quality from fair to good, but their facilities were invariably less elaborate than the Americans' and their personnel less numerous. No possibility existed of putting one or more at each level of evacuation to see to the needs of their own wounded and sick and to serve as interpreters. Despite this, and despite some difficulty caused by varying demands for rations, treatment proceeded without interruption. The pattern of the integrated medical system was like a river in which tributaries rising in many nations flowed into an American mainstream.³⁰

Life on the Line

In units not directly involved in the fighting, in those temporarily in reserve, and in all units during the summer and winter lulls, life had changed utterly from the days of fluid warfare. Units remained stationary for months at a time. Patrols went out accompanied by aidmen and Korean litterbearers. In the

³⁰Military History Section, FEC, "History of the Korean War," vol. 3, pt. 2, sec. B, "Inter-Allied Co-operation During Combat Operations," pp. 138–46, Ms no. 8–5.1A AI V1, RG 319, MMHB. The rotation system is treated at some length in Chapter 7 of this volume. In December the 1st Cavalry Division moved to Japan and the National Guard's 45th Infantry Division took its place on the line.

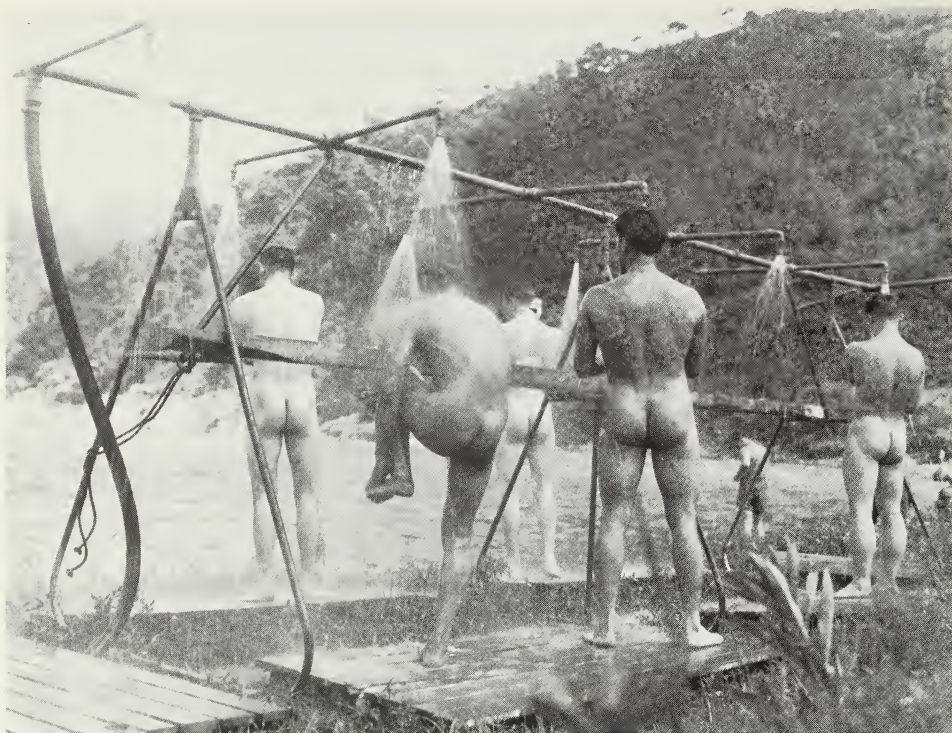
bunkers men counted the time until rest and recuperation (R&R) leave gave them a few days off, either in Seoul or in Japan, and added and readded their rotation points. The arrival of replacements was always cause for rejoicing. In medical units frequent movies and increasing stocks of athletic equipment helped to while away the time. Some men and women enrolled in study courses, and day rooms in squad tents provided books and magazines for those stationed near a division headquarters. The character of medical work changed also. In the 25th Division battle casualties reached a high of nearly 800 cases per 1,000 troops per annum in June, fell to less than 100 in July, rose sharply during the September–October fighting, and plummeted almost to none during December. Whatever the course of battle, casualties from sickness consistently outnumbered the wounded once the fighting of the spring had ended.³¹

Preventive medicine became correspondingly important. Aided by a stable front and by what a division surgeon called “good fortune with the environment,” medics assured U.N. forces systematic care and generally good health. Problems were primarily those of administration. Individual “shot registers” held by soldiers deteriorated from usage and perspiration and were frequently lost. Keeping systematic immunization registers was a tiresome but necessary chore, and administering repetitive inoculations and boosters, checking vaccinations, among other measures, were an essential part of preventing disease. Another was insect control. Malaria control teams guided antimalaria details, appointed by each company or battery commander. Sprayers and dusters were issued down to company level, and the tents, bunkers and trench lines were soaked in residual DDT spray and DDT powder. Mosquito netting was used in all areas except the front lines, and chloroquine was issued to the men under the customary tight controls. Flies, like mosquitoes, were reduced in numbers, and control of water supplies, burying enemy corpses, and disinfecting and burying body wastes helped to keep dysentery to an insignificant level.³²

The quieter front, R&R leaves, and contacts with villages up and down the main supply route all helped to bring venereal disease back as an annoying, though not militarily significant, problem. A division surgeon philosophically viewed the problem as “an occupational disease of soldiers,” but that did not prevent determined efforts to keep it under control. Nonpunitive measures were in force, for punishment often led only to evasion and self-treatment. Divisions set up VD clinics, maintained syphilis registers, and held frequent lectures of the sort that emphasized man-to-man candor, appeals to moral sentiment, and so forth. Divisions also supplied prophylactic kits and condoms, which were freely distributed at “orderly rooms, latrines, MP stations, town service [clubs], officers’ clubs and all dispensaries.” A common method of control was that staple of ribald and rueful GI memory, the physical inspection. This ritual was performed before men went on R&R leaves and after they returned, on newly arrived replacements and on men leaving for home. Dr. Hawkeye Pierce, fic-

³¹25th Infantry Division, Annual Report of Medical Service Activities, 1951, Encl 2, HRB; 25th Medical Battalion Command Report, September 1951, file 325–MED (Command Report, 25th Medical Bn, 25th Inf Div, Sep 51), Box 3870 (25th Inf Div, 325–MED, 25th Inf Bn, Jan–Oct 51), Entry 429, RG 407, MMFB.

³²1st Cavalry Division, Annual Report of Medical Service Activities, 1951, pp. 7–8, HRB.



QUARTERMASTER SHOWER POINT *on the Songgang River*

tional hero of the popular novel *M*A*S*H*, gave instructions for carrying out a short-arm inspection that can hardly be improved upon. "It is very simple," Hawkeye explained.

You get a chair. You sit on it backwards with your arms clasped behind its back and your chin resting on the top. You gotta have a big cigar in your mouth. You sit there and look. Most of the guys will know what to do. If they don't you growl, 'Skin it and wring it, soldier.' Sound mean when you say it. If you think there is a suspicion of venereal disease, you make a gesture with your thumb like Bill Klem calling a guy out at the plate. Then somebody hauls the guy off somewhere. I never found out what happens to them. Every now and then, just so they know you're alert, you grunt, 'Don't wave it so close to my cigar, Mac!' If you follow these simple rules, you can't go wrong.³³

By far the greatest problem in both the prevention and treatment of disease, however, was an illness for which, in the beginning, the medics did not even have a name.³⁴ The center of the outbreak was a region north and northeast of

³³First quotation from *ibid.*, p. 11, HRB. Second quotation from Richard Hooker [H. Richard Hornberger], *M*A*S*H* (New York: Pocket Books, 1968), p. 178. Hornberger served as a MASH surgeon during 1952–53.

³⁴The following section on what was later identified as epidemic hemorrhagic fever is based on a great number of sources, among which the following are important: FEC, Annual Report of Medical Service Activities, 1951, pp. 54–55, file 319.1–2 (FEC) Far East–1951; 121st Evacuation Hospital, Annual Report of Medical Service Activities, 1951, pp. 20–22; 8228th MASH, Annual Reports of Medical Service Activities, 1951 and 1952, pp. 1–4 and pp. 1–2, respectively, files 319.1–2 (MASH,

Seoul along the 38th Parallel, in the I and IX Corps areas. U.N. forces had entered the endemic region for the first time during the fall of 1950, passing rapidly through it on their way north. Again, they had fought there during the spring of 1951, but in a war of movement. Now they lived there, month in and month out, in daily contact with soil and water, insects and flora, and the wild rodents that came to their bunkers, attracted by food and warmth. If scattered cases had occurred before, they had remained unrecognized. But beginning in June 1951, as many cases of a little-known disease flooded the hospitals, American military medicine had no choice but to take notice.

The illness was painful in its onset, often fatal in its course. Sore throat, headache, nausea, and backache marked the first phase, followed quickly by the appearance of red spots on the soft plate, in the armpits, and on the chest. The patient was thirsty; he drank heavily and doctors, fearing dehydration, administered intravenous fluids. In the second phase the temperature fell, as did the blood pressure. Weakened vascular walls were allowing blood fluids to seep into the tissues—hence the thirst and hemorrhagic symptoms. As the victim slipped toward hypotensive shock, his vision became blurred and mental confusion sometimes ended in delirium, convulsions, or coma. Capillary bleeding, the crux of the disease to this point, became more marked, with swollen eyelids and multiplying red spots; sometimes the patient's extremities became blue and cold. In the next phase the kidneys ceased to function, resulting in accumulations of fluid in the lungs, dangerous levels of urea in the blood, and irritable outbreaks that sometimes verged on mania. This phase ended in a profuse diuresis, followed on occasion by new manic episodes as the depletion of essential chemicals by the body's falling fluid levels disturbed the electrical functioning of the cells. Then came a rapid subsidence of symptoms and the beginning of a long convalescence, marked often by continuing inability to concentrate the urine.

This formidable disease produced, in some line units, an early mortality of 20 percent among those affected and was variously diagnosed as leptospirosis, malaria, infectious hepatitis, fever of undetermined origin, and even leukemia. The 1st Cavalry Division, whose fate during 1951 seemingly was to be in the wrong place at the wrong time, suffered more than any other division, reporting 42 percent of the 887 cases and 42 percent of the deaths. Treatment at division level was impossible, and both treatment and clinical investigation fell to the 121st Evacuation Hospital. At first the hospital kept all patients, until an ex-

8228th Army Unit) 1951 and 1952; 1st Cavalry Division, Annual Report of Medical Service Activities, 1951, pp. 8–9; FEC and USAFFE, Annual Report of Medical Service Activities, 1952, app. IX, Preventive Medicine Division sec.; JLCOM, Annual Report of Medical Service Activities, 1951, p. 45, file 319.1–2 (JLCOM) Far East–1951. All in HRB. See also 406th Medical General Laboratory, Report of ETMD, December 1951, p. 14; Interv, author with John W. Vester, M.D., 5 Feb 81, HSF (Vester Intervs), HRB; Rpt, Capt Ralph M. Takami, Medical Intelligence and Epidemiology Officer, Medical Section, FEC, 13 Aug 51, sub: Epidemic Hemorrhagic Fever, file 710 (Songo Fever), Box 9431 (Public Health and Welfare Section), RG 331, MMFB. For contemporary printed records, see "Commission on Hemorrhagic Fever," in *Collected Reprints of the U.S. Armed Forces Epidemiological Board*, vols. 11 and 12 (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1953 and 1954), where a number of important papers and symposia are conveniently reprinted. For early references, see War Department Technical Bulletins MED 88,

(Continued)

traordinary surge in October—when incidence rose from 1.8 to 8.9 cases per 1,000 troops per annum—forced evacuation of 500 victims to Japan. Death rates ran to 8 percent in the early days at the hospital, though this would fall later, while the Far East Command reported an overall death rate for the year of 7 percent.

Efforts to find out more about the disease took many forms. References to epidemic hemorrhagic fever occurred in several Army manuals. Japanese and Russian reports also were found, for both nations had encountered it, the Japanese in the Songo region of Manchuria in 1939. In the forties Japanese researchers using human subjects—"it is strongly suspected by some of our staff," wrote General Hume, "that the anthropoid apes on whom they experimented were really prisoners of war. . . ."—concluded that the disease was caused by a filterable virus and transmitted by a mite whose host was a common field rodent.³⁵ With these hints turned up by medical intelligence and with translations of the foreign reports sent by the Army library in Washington, field research took over and predominated until late in the year. At the 1st Cavalry Division, members of the 37th Preventive Medicine Company checked out case histories in an effort to pin down the precise area of infestation, running into a maze of difficulties because the disease had a long incubation period, troop units moved about, and towns had interchangeable Japanese and Korean names. A preventive medicine detachment of the Mobile Medical Laboratory, 8217th Army Unit, trapped live rodents and catalogued their parasites. In November the Far East Command, moving to bring some order into random research efforts among unit medics, set up a laboratory at the 121st Evacuation Hospital, where a research team under Capt. Julio Barbero of the Medical Corps launched a detailed study of 30 representative cases. Meanwhile, at Osaka Army Hospital Capt. George M. Powell, also a Medical Corps officer, embarked on a statistical analysis to uncover the disease's epidemiological pattern.

Unfortunately, none of the information that was gathered proved to be of much value in meeting the autumn epidemic. Tests at the 406th Medical General Laboratory in Japan failed to find the cause of the disease. Lacking this, neither vector nor host could be confirmed. No cure was found. The new epidemic rise peaked in November with 356 fresh cases. Meanwhile, epidemic hemorrhagic fever in Korea met its only effective counter in better management of the patient and more adept nursing. Medics learned how to handle a disease they could neither prevent nor cure. In particular, the careful and tedious monitoring of the patient's urinary output proved essential in dealing with the critical changes in the body's fluid levels. Round-the-clock care was essential.

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Medical and Sanitary Data on Khabarovsk Krai and Maritime Krai (Far Eastern Territory), U.S.S.R., 29 Aug 44; MED 208, Medical and Sanitary Data on Korea, December 1945; and MED 216, Medical and Sanitary Data on Manchuria, February 1946, in Medical Collection, HRB. For the present view—that the disease is caused by a virus infecting common field rodents—see Tinsley Randolph Harrison, *Harrison's Principles of Internal Medicine*, ed. Kurt J. Isselbacher et al., 9th ed. (New York: McGraw-Hill, 1980), pp. 840–42.

³⁵Ltr, Maj Gen Edgar Erskine Hume, Chief Surgeon, Medical Section, FEC, to Maj Gen George E. Armstrong, Surgeon General, DA, 24 Aug 51, p. 4, file 319.1 (Far East Command) AA, 1951–52, Box 69, Accession no. 56A–179, RG 112, WNRC.

Doctors slept at their patients' sides to be available when some new crisis developed. Nurses bore the brunt of the burden, and enlisted corpsmen performed the ceaseless monitoring of the urine. Understanding the course of the disease permitted better care, and proper nursing enabled the victim's body in all but the most serious cases to cure itself.

In December 1951 hemorrhagic fever claimed 118 new patients, but then fell off rapidly, reaching zero incidence in March 1952. It was obvious, however, that warm weather would bring another outbreak. In April the 8228th MASH—a unit that had existed for some time on paper but had only begun to come to life during the closing months of 1951—became fully operational as the Eighth Army's designated hemorrhagic fever center. Its mission was to provide a specialized hospital near the center of the infected area, permitting short hauls for the helicopters and quick treatment for the patients. Located at Songu-ri northeast of Seoul, the unit under Lt. Col. George S. White presented the paradox of a surgical hospital without surgical duties.

As the new season began in May with a fifteen-fold rise over the initial small April total, the 8228th MASH got down to business. Because hemorrhagic fever was grounds for helicopter evacuation, the 8228th during 1952 received almost all its 885 confirmed cases by air. Never had the helicopter been more important, for any rough movement could rupture the patient's weakened vascular walls, causing fatal hemorrhages. At the MASH systematic study under field conditions still failed, however, to provide a diagnostic test or to identify the vector with certainty. Mortality in the spring outbreak—the two humps in yearly incidence remained remarkable features of the disease—was 5.22 percent and in the fall, 5.11 percent.

Other efforts at control through the methods of preventive medicine produced dubious results. On the assumption that mites were the vector (and similarity in the pattern of incidence to mite-spread scrub typhus made this seem likely) the Eighth Army launched a program to soak all clothing in a miticide. Rodents also were trapped and poisoned. Yet at the end of 1952 the problem had not abated from a year earlier, except for the steadily decreasing mortality. Case rates never again reached the shocking 18 per 1,000 of November 1951, when the steepness in the disease's rise seemed to threaten a major epidemic. As a menace, epidemic hemorrhagic fever faded, for the medics had learned how to cope. As a mystery, it remained little less obscure than when it first appeared.

How Good Was the Field Medical Service?

Despite the mystery of epidemic hemorrhagic fever, medics had good reason for pride over their performance in Korea. Statistics indicated that they were saving record numbers of the casualties who had reached the hospitals. Buoyed by these results, the medics sometimes exhibited a self-congratulatory mood, tempered by their belief that in future wars the casualty and death rates would go "up as sure as the world." On his return home from the Far East Command, in May 1951, however, General Sams opened a sharp debate, imperfectly shielded from the public, over the effectiveness of Army medics in getting the



MAJ. GEN. GEORGE E. ARMSTRONG

wounded off the battlefield and into the hospitals. Charging that front-line evacuation was actually less effective in Korea than during World War II, he questioned the effect of the prewar professionalization program upon the practice of field medicine.³⁶

When Sams left Tokyo for home, he could look back not only on remarkable achievements in public health and his recent adventure in North Korea but also on a shocking personal loss and a major professional disappointment. On 27 November 1950 his son-in-law, Capt. Charles M. Struthers of the Medical Corps, lost his life defending his patients during the Chinese attack on the 2d Division. Sams knew that Struthers had fired a weapon for the first time only a few months earlier during an enemy attack

on his aid station in the Pusan Perimeter. Like so many other young residents, Struthers had passed direct from the corridors of Letterman General Hospital as a specialist in pathology to a front-line aid station as a battalion surgeon, ill-prepared for his assigned responsibilities and largely ignorant of field procedures, organization, and weapons. Sams, by contrast, was a product of the Medical Department of the late 1920s and 1930s, when most medical officers had lacked specialized professional training but had acquired broad experience as soldiers.

In the spring of 1951 came a blow of quite a different kind when President Truman relieved General MacArthur of his command. Sams had expected to become surgeon general of the Army, but those who were known as "MacArthur men" also fell with their chief. Maj. Gen. George E. Armstrong became the new surgeon general. As a result, when Sams raised sharp questions about medical training and went at least partly public with them, some of Armstrong's supporters—and perhaps the surgeon general himself—saw his action, in the words of General Hume, as motivated by "bitterness [and] envy."³⁷

Yet Sams was not alone in raising the issue of the Medical Service's effectiveness on the front lines. The famed Dr. Charles H. Mayo expressed the belief that soldiers wounded in Korea were more likely to die in aid stations than were marines. Anna M. Rosenberg, the assistant secretary of defense, concerned

³⁶Quoted words from statement of Maj Gen George E. Armstrong in Transcript of the Meeting of the Board on Dispensary and Field Medical Service of the Army, 14–15 Sep 51, p. 48, file 334 (Martin Board), Box 34, Accession no. 58A–1095, RG 112, WNRC.

³⁷Ltr, Maj Gen Edgar Erskine Hume, Chief Surgeon, Medical Section, FEC, to Maj Gen George E. Armstrong, Surgeon General, DA, 6 Sep 51, p. 4, file 312.3 (Correspondence—SGO—Washington), Box 3124 (Medical Section, FEC, General Records, 1951), RG 338, MMFB.

herself particularly with questions relating to the people of the armed services. Known for her sharp tongue, rough language, and penchant for asking pointed questions and insisting on replies, Rosenberg had a faculty for making even generals uneasy. She queried Dr. Richard L. Meiling, chairman of the Armed Forces Medical Policy Council in the Office of the Secretary of Defense about Mayo's charges. Thus when Sams spoke out, the demand for answers converged on the council from two directions.

At Meiling's invitation, Sams attended the regular meeting of the Armed Forces Medical Policy Council on 18 June.³⁸ Here Sams recalled that MacArthur, as a special additional duty, had ordered him to inspect the front-line medical services at frequent intervals. Viewing American dead, he often wondered "whether the men would [have] lived or died if they had reached a medical installation." Of the quality of the front-line hospitals and the professional care available in them he had no doubt: "I think they are unequalled by any I have seen anywhere in the world." But "our death rate—talking about men who are hit—is far higher than the last war because many do not reach the hospitals. . . . My impression is about 4,000 men [who have died] should be alive."

Sams linked defective evacuation directly to that centerpiece of Army medical policy since World War II, medical specialization and professional development. The civilian medical profession had specialized, indeed overspecialized, he held, and the Army had followed suit with beneficial effects as far as hospital medicine was concerned. But the trend had gone too far and had brought adverse effects as well. Military medicine was not, and could not be, the same as its civilian counterpart. It most resembled civilian medicine in the hospitals. It differed widely in preventive medicine, because soldiers lived so differently from civilians. It differed absolutely in "the evacuation of battle casualties, and that has no parallel in civilian medicine. That particular responsibility we are now failing in." Because Army training had followed the civilian model too slavishly, many a young man in Korea had faced an impossible situation.

Our younger men were thrown into combat without a day's training—similar to taking a boy out of a drugstore and saying 'I'll give you a gun—go fight the Koreans.' We did this to our young doctors. They were pulled out of the specialty programs, arrived in Japan, because we had nothing else; given field equipment which they had never seen before, told they were going to be assigned to field units the names of which meant nothing to them. Those young men, within five days after their arrival, were being shot at by the enemy. . . . That, I think, was one of the most disgraceful things in the military service. And still, a year later, we are almost in the same fix insofar as the men who are physically in the forward echelons are concerned at this time.

³⁸The account that follows is drawn primarily from the minutes of the Armed Forces Medical Policy Council, files 334 (AFMPC), Boxes 32–35, Accession no. 58A–1095, RG 112, WNRC. Quotations by Sams are from transcript of 18 June 1951 meeting, filed with the minutes of the 30 June meeting. The surgeon general's quoted reaction to Sams' presentation is from the 30 June minutes. Sams later elaborated on his argument to Brig. Gen. Frank Berry, the assistant secretary of defense for medical affairs. See Memo, Sams to Berry, 18 Jun 54, Personal file (1 Apr–30 Jun 54), Crawford F. Sams Collection, Hoover Institution Archives, Stanford, Calif. See also Interv, author with Sams, 28 Sep 82, HSF (Sams–1982), and Ltr, Sams to author, 29 Aug 83, HSF (Sams–1983). Both in HRB.

Sams went on to compare the record of the Army with that of the Marine Corps, particularly at the Changjin Reservoir where the marines brought out not only "all of their wounded but also many of their dead." By contrast, on many occasions the Army, in withdrawing, had abandoned its wounded. This was not the sort of statement the council expected to hear from an Army medical general.

Reaction to his presentation—and to his later open discussion of the issue at the Atlantic City meeting of the American Medical Association—was vigorous, especially on the part of the surgeon general. On 30 June Armstrong declared that he felt "no little surprised to learn of General Sams' biased report to the Armed Forces Medical Policy Council." When Meiling took Armstrong to task for his "defensive attitude," the surgeon general assured him that in the near future he would go on an inspection trip to the Far East and would look into the matter.

Meiling then revealed that on the day before he had discussed the issue with Rosenberg and Robert Lovett, the under secretary of defense, and had given them a report for George C. Marshall, the secretary of defense. Meiling recommended that the field medical services of all three service branches be brought up to the same level of efficiency as hospital medicine; that a board of the three service secretaries be appointed to find ways and means; that the Army and Air Force be given authority to create an enlisted hospital corps similar to that of the Navy; and that the fact be reemphasized that evacuation was a command responsibility. (Navy corpsmen, who also served the marines, received more vigorous specialized training than Army enlisted medics and, once trained, remained in their specialty.) The chairman added that the board he wished to set up should be on the secretarial level because "top patronage" would be needed in order to carry it through.

Meanwhile, a memo drafted for Armstrong's use at the session—perhaps by Col. Warner F. Bowers, a Medical Corps officer assigned to the Office of the Surgeon General—admitted that many junior officers who were residents in the Army's professional training program had entered Korea without field training. "The situation (known to all of us) that existed in the medical profession during the postwar years precluded the training of any considerable number of medical officers in field medicine. [But] no time was it the policy of the Surgeon General to discontinue or discredit field medical training" at the Medical Field Service School at Brooke Army Medical Center in Texas, even though the September 1950 class was broken up to provide medical officers for the Far East. Now "new and improved courses have been devised and classes this year are already selected." Doctors brought in under the draft would get five weeks of training in Texas before going to their first assignment. In any case, Bowers implied, defective training meant little because field-grade medical officers in Korea had either field training or experience, and Medical Service Corps officers had been trained in field medical procedures.³⁹

³⁹Col Warner F. Bowers, MC, OSG, 15 Oct 51, sub: Status Report on Army Dispensary and Field Medical Service, file 334 (AFMPC), Box 34, Accession no. 58A-1095, RG 112, WNRG.

Indeed, there was little to be done with this part of Sams' charge, except to admit its truth and aver that changes were under way. Some residents had received no field training at all prior to combat. Those who had completed their studies, and begun their obligated time of service, received at the Medical Field Service School a brief introduction to military lore that, in the view of many, was ineffective. In a survey conducted in Korea during March 1951, Eighth Army doctors reported that they needed more training in a variety of basics: in map reading, in setting up and packing medical and dental chests under field conditions, on the chain of command, and on their "specific duties as Battalion or Regimental Surgeon[s]." Additional training, they felt, was needed in field tactics and the organization of a medical company. A division surgeon opined that medical officers should learn more about tactical defense of a medical field installation, how to set up a perimeter defense, and how to use the hand grenade and bayonet. For existing deficiencies the doctors admitted that the Medical Service was not alone at fault. "All officers," concluded the report, "felt that the course [in field medicine] would have been of more value if they had been impressed with its usefulness." But "at that time the majority were preparing to specialize in surgery, X-ray, laboratory, therefor[e they] had little or no interest in field medicine."⁴⁰

Some officers who could have contributed to the debate were not available in 1951, for they were POWs in enemy prison camps, where they would remain until 1953. Capt. Alexander Boysen has appeared once in this narrative, at the time of his capture; he will appear again on a death march in North Korea. During a debriefing in Washington following his liberation, he remarked that if medical officers in Korea in 1950 "had had any field training, which he regretted not having, a good number of men and equipment [*sic*] could have been saved and gotten out. They could at least have known something about the tactics being used." Another returnee bluntly told a gathering of medical generals, "I went to the Medical Field Service School in 1947 and I feel that it was a complete waste of my time." Capt. Sidney Esensten of the Medical Corps continued: "I didn't learn anything about taking care of people in the Army; and I didn't know what a gun looked like; I didn't even know how to head up a medical unit."⁴¹

Soon the Eighth Army surgeon was to protest that a military assignment now seemed paradoxical even to Regular Army medical officers whose viewpoint had been thoroughly professionalized, to say nothing of the drafted civilians who saw military service as an intrusion upon their lives. His devastating conclusion was that "most of the young doctors coming to Korea have not been given the word on the simple fundamentals of the care of the wounded man, or of the problems involved in the management of battle casualties." To remedy this, Brig. Gen. L. Holmes Ginn, Jr., a graying, acerbic medical officer of the old

⁴⁰EUSAK, Report of ETMD, March 1951, pp. 30–33. First quotation on p. 30; second and third quotations on p. 31.

⁴¹Medical Corps, OSG, U.S. Army, 1 Dec 53, sub: Report of Conference With Repatriated P.O.W. Personnel, Document no. LD 1192897 F, Box 584, Accession no. 59A801, DIA Archives, Washington, D.C.

school, later developed an extensive program of field training within Korea itself.⁴²

But the first reaction, not only of the surgeon general but also of the men in the field, was defensive in the extreme. In the summer of 1951 Armstrong visited the Far East Command and personally questioned both line and medical officers on the efficiency of front-line evacuation. According to his memorandum on the trip, all without exception reported that it was superb. Meanwhile, Meiling's report had ascended to the desk of the secretary of defense and returned as a directive to the three service secretaries. Each was to appoint a board of officers in his own department to prepare and implement plans for bringing the field medical service for the combatant forces up to the level of competence already existing in the hospitals.⁴³

In turn the secretary of the Army ordered Armstrong to appoint the board,⁴⁴ which met in the Main Navy Building on 14–15 September under its president, Maj. Gen. Joseph I. Martin of the Medical Corps. After some discussion of the scope and form of the report to be written, General Martin in effect gave the board its marching orders.

"We don't want," he said, "to get into the attitude of admitting that we have had a poor field medical service, you see."

"Let's by all means avoid being on the defensive," Colonel Bowers agreed. Martin then continued:

Let's take the offensive and show in our background [section of the report] what we have actually done; and where somebody could tear it to pieces as a weakness, then only include something that was a fact and not explain that fact too much. We all know personally, for instance, there was a terrific urge to get people for the Regular [Medical] Corps and the trend was [to say] we will offer the man something professionally, put the field aspects of medicine on a quietus status until we get them in, and then ease them into field medicine as a field later on; and unless we do that we get no one. We all know that, but I do not think we need to mention it in those words. . . . I still maintain we have a good Medical Service but never that it cannot be improved, but any improvement shown [i.e., recommended in the report] is going to be minimum—that is personally what I would like to see the Board come up with.

Having settled their conclusions, the board turned to taking testimony. First to appear was Surgeon General Armstrong. It quickly became apparent that Armstrong intended to speak candidly, at least in private. He deprecated his own report on the Far East Command: "This report of mine . . . was written perhaps with something in the back of my mind which for the moment I will try

⁴²EUSAK, Annual Report of Medical Service Activities, 1952, annex VII, p. 2, file 319.1–2 (EUSAK) Far East–1952, HRB. Colonel Ginn replaced Col. Thomas N. Page as Eighth Army surgeon on 27 January 1952.

⁴³MFR, Maj Gen George E. Armstrong, Surgeon General, DA, 31 Aug 51, sub: Inspection Trip to the Far East Command, 331.1 (Far East Command) AA, 1951–52, Box 69, Accession no. 56A–179; Transcript of the Meeting of the Board of Dispensary and Field Medical Service of the Army, 14–15 Sep 51, p. 22. Both in RG 112, WNRC.

⁴⁴Quotations in this and the following three paragraphs from Transcript of the Meeting of the Board of Dispensary and Field Medical Service of the Army, 14–15 Sep 51, pp. 6–7, 45–52, RG 112, WNRC.

to disabuse myself of and think again . . . not in the defensive attitude that perhaps I may have taken here [indicating report]." As against Sams he strongly felt "that our current program of field training of five weeks is sufficient" for junior medical officers; forty-eight hours of field experience and the assistance of Medical Service Corps officers and a leavening of trained enlisted men should enable most of them to perform well. But he saw a weakness in another place. The most important element in the whole medical system was the medical aidman, and here, according to Armstrong, training was clearly inadequate. A third or more arrived through the replacement pipeline with no medical training and the best the divisions could do was "to give them a 'quickie' three-weeks course which, believe it or not, in general satisfied the line, and in general satisfied the front-line Medical Corps officers, but that does not make it right." Six to eight weeks of basic medical training should be the minimum.

Another problem was the lengthy litter carry that typified Korea—"this one-half day or six-hour litter haul." Korean topography and the quirky nature of helicopter evacuation seemed to preclude any reduction. The seriously wounded man for whom a helicopter was unavailable was "still a long way from major surgery." Perhaps aidmen, with some training, could take over and begin treatment for shock—"we see pictures of men, enlisted men holding bottles of blood plasma and whole blood, but it is always in the aid station." Meantime, despite the vaunted helicopter, it was a long way for most wounded from the front line to the aid station, and again from the aid station to the MASH.

How could death rates be lowered further? Means other than clinical were needed. Body armor, improved training for aidmen, and treatment for shock forward of the aid station might be the answer. Too many autopsies showed death due to kidney failure resulting from hypotensive shock. Perhaps the MASH could move forward, closer to the line, and in bad weather, when helicopters were grounded, MASH surgical teams could move forward to the clearing stations to begin treatment. As for the rotation system—soon to bring maximum personnel turbulence to the front lines where trained men were already at a premium—the surgeon general's opinion was blunt: "This matter of rotation for the Medical Corps officers is a thing which you can discuss for hours and hours, and on paper it looks all right but in the field it is 'bunk', as you all know."

The board followed the line set by Martin and produced a document similar in many respects to a corporation's report to its stockholders. It did, however, endorse the proposals made by Meiling and contained in the directive of the secretary of defense, including one for which the Medical Service had long campaigned, a Medical Enlisted Corps equivalent to the Navy's Hospital Corps. Here, however, Meiling, the board, and Secretary of Defense Marshall all ran afoul of the Army's centralizing policy. The Army disapproved the proposal on the grounds of opposition to "any recommendations which tend to establish a cellular autonomy within the over-all staff and command structure."⁴⁵

⁴⁵Twenty-fourth Meeting of the Armed Forces Medical Policy Council, 4 Feb 52, file 334 (AFMPC), Box 33, Accession no. 58A-1095, RG 112, WNRC. The Office of the Surgeon General

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Sams' accusation that front-line evacuation was less efficient than in World War II had meanwhile become mired in competing statistics. Armstrong believed that his report on his trip to the Far East Command had quieted the policy council, the General Staff, Pace, and Lovett. "I have not, however, satisfied Mrs. Rosenberg," he confessed to General Hume. The result was a long and closely reasoned memorandum to Rosenberg in which Armstrong put forward a creditable statistical argument. He first noted that those who died of wounds in medical facilities to date represented 2.4 percent of those wounded in action, as compared to 4.5 percent in World War II. But then he raised the real question: Were those killed in action actually wounded men whom the evacuation system had failed? The question in essence was whether the decrease in the case fatality rate was accompanied by an increase in the proportion killed in action. In World War II 293 were killed in battle for every 1,000 wounded or injured in action; in Korea the number had decreased to 225. By his own calculations the overall ratio of deaths by hits (that is, killed in action or died of wounds) per 1,000 reported hits had fallen from 261 to 203. Upon this analysis he rested the question of the adequacy of front-line evacuation, and by implication the competence of the men who directed it.⁴⁶

Armstrong's figures, however, differed from those later derived by Medical Service statisticians who studied World War II casualties. A question remained also with respect to the total figures of the men missing in action (MIAs). Sams later averred that the excessive number of MIAs, and the impossibility of accounting for more than about half from the number of POWs known to be held in North Korea, had provoked his own early doubts about front-line evacuation. Figures submitted to the policy council showed that, as of 20 April 1951, MIAs were equal to 27 percent of the total of wounded for the Army, less than 3.5 percent for the Marine Corps (*Table 9*). Striking too was the fact that the ratio of killed in action to wounded in action for the period of active warfare was 1 to 4 for the Army, only 1 to 6 for the Marine Corps. End-of-war statistics would present a suggestive picture. The adjutant general was ultimately to declare 3,791 MIAs dead and 2,294 more dead of nonbattle causes while captured or missing. The ratio of all battle deaths, including MIAs declared dead, to surviving wounded plus battle deaths was higher in Korea than in the European theater of World War II, though lower than in the war as a whole, and much lower than in the Pacific theaters.⁴⁷

It was not clear, however, that any single factor, such as Sams' indictment of Army training programs, could explain these figures, or the difference between the Army and the Marine Corps in Korea. Broad qualitative differences existed between the two services that fought the Korean ground war. The unity of a

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ordered twenty-five thousand copies of the Martin board report and distributed them as a public relations document.

⁴⁶Memo, Maj Gen George E. Armstrong, Surgeon General, DA, to Anna M. Rosenberg, Assistant Secretary of Defense, 10 Sep 51, sub: Battle Casualty Data, p. 2, file 312.3 (Correspondence—SGO—Washington), Box 3124 (Medical Section, FEC, General Records, 1951), RG 338, MMFB.

⁴⁷Frank A. Reister, *Battle Casualties and Medical Statistics: U.S. Army Experience in the Korean War* (Washington, D.C.: Office of the Surgeon General, Department of the Army, [1973]), p. 15.

TABLE 9—BATTLE CASUALTY DATA, APRIL 1951^a

Category	Army	Marine Corps	Total
Wounded in Action			
Died of wounds	826	243	1,069
Surviving wounded	32,539	7,287	39,826
Total	33,365	7,530	40,895
Killed in Action			
Total	7,861	1,279	9,140
Missing in Action			
Died	88	88
Returned	1,126	1,126
Captured	110	110
Currently MIA	8,937	262	9,199
Total	10,261	262	10,523
Grand total	51,487	9,071	60,558

^aBased on notification up to 20 April.

Source: Minutes of the Armed Forces Medical Policy Council, 30 Apr 51, file 334, Box 35, Accession no. 58A-1095, RG 112, WNR. Deaths totaled 10,297—8,775 for the Army and 1,522 for the Marine Corps.

small, elite, professional service imbued with powerful esprit de corps contrasted sharply with the looseness of the Army's varied contingents, heavily laced with draftees. Marine spirit found a practical expression in the policy, which Sams had noted, of carrying out their wounded and their dead. Finally, Army training of aidmen, as Armstrong remarked, was often deficient.

More complex was the comparison between Korea and the two major theaters of World War II. In the manner of warfare and the short evacuation distances, Korea resembled the European Theater of Operations more than it did the Pacific, where jungles and interminable evacuation routes caused the loss of many wounded men. That Korea should show better statistics than the war against Japan was only reasonable. But why did it show worse results than the European theater? The roadlessness, primitive conditions, and harsh topography of Korea were certainly basic reasons. The enemy there routinely tried to kill medics and destroy medical vehicles, while the European Axis powers usually had obeyed the conventions of warfare in dealing with the Western Allies. North Korean and Chinese tactics of infiltration and encirclement fatally disrupted medical evacuation, except by helicopter, for the whole concept of evacuation as conventionally practiced in Western warfare rested upon the willingness of armies to deploy in a front so that forward and rear areas could be distinguished. Above all, the tumultuous retreats of 1950–51 had no analogue in the European theater, except in the Battle of the Bulge.

The practical results of the controversy that Sams had launched were largely positive. More rigorous field training was undertaken both in the zone of interior and in Korea. By autumn aidmen were giving plasma, or, in very cold weather, serum albumin. In September 1951 Surgeon General Armstrong appointed General Sams assistant commandant of the Medical Field Service School, a post which he retained until June 1953, under General Martin as commandant. Despite friction between the two, Sams reorganized the course in

field medicine to emphasize demonstration and practical exercises by the students. In Korea, because the war of movement had ended, General Ginn launched his ambitious training program for both officers and enlisted men. "Field training with a division," he declared, "is an indispensable ingredient of [the medical officer's] education, especially if he is in the regular service, no matter how rarified and sacrosanct his MOS[;] . . . along with knowledge and skill, a young medical officer must be taught a sense of mature responsibility toward his patients which comes from experience and from living with his mistakes." Few could dispute Ginn's goal of giving his doctors "an impressive post graduate training bearing the stamp of the Eighth Army and unattainable in kind anywhere else in the world."⁴⁸

The controversy also served to put the achievements and limitations of the Medical Service in a more realistic light than subsequent legend would allow. It now seems clear, with the documents available to scrutiny, that one of the most frequently repeated statements about the war, that death rates among the wounded in Korea were reduced below World War II levels, must be limited to the wounded who reached the hospitals before it can be fully accepted. Too often the nature of the war, the topography of the land, and the Army's system for obtaining aidmen and training doctors and enlisted medics alike combined to prevent the wounded from reaching the clinical miracles that waited in the hospitals. Once there, casualties received exceptionally competent care. No single cause can be given praise and blame for that mixed record, but the evolution of Army medicine between the wars was a basic factor. So, too, was the general course of American medicine during those years, remote as its professional and scientific concerns may have appeared from the battlefields and bunker lines of Korea.⁴⁹

⁴⁸EUSAK, Annual Report of Medical Service Activities, 1952, annex VII, p. 3, HRB.

⁴⁹Ltr, Col Douglas B. Kendrick, Jr., MC, Chairman, Blood & Blood Derivatives Group, Office of the Directorate, Armed Services Medical Procurement Agency, to Chief, Supply Division, OSG, 30 Nov 51, sub: Recommendations for Use of Serum Albumin in Place of Blood Plasma by Field Medical Units in Korea During Cold Weather, file 444.2 (Korea) F, 1951-52, Box 50 (Geographic Files, 1951-53, 386.3 (Korea) F to 721-End (Korea) F), Accession no. 56A-198, RG 112, WNRC. Questions similar to those treated in this section have been raised regarding Vietnam casualties. See Karl D. Bzik and Ralph F. Bellamy, "A Note on Combat Casualty Statistics," *Military Medicine* 149 (April 1984): 229-30.

CHAPTER 7

Static Warfare

The winter of 1951–52 brought scattered fighting along the line. The cold ought to have been an ally of the United Nations (U.N.) forces, who were better equipped than the enemy and, except for the South Koreans, better fed. But there is little evidence that it was. By Korean standards the weather was relatively mild. Yet cold injury was distressingly common by any standards, except those of the preceding year. The troops, especially newcomers brought in by rotation, showed little skill in protecting themselves. An Army winter environment team found a lack of ingenuity in the construction of warming bunkers. The troops apparently were intimidated by winter weather, despite the fact that geography had granted them the south slopes of the hills. Some combat patrols were so brief as to be ineffective. Except during enemy attacks, hospitals received a mere trickle of battle casualties, and medical problems dominated their work.¹

Yet such generalities did not do justice to many a bitter action. Aidman Pfc. Bryant E. Womack of the 14th Infantry, 25th Division, was the only medic with a combat patrol that suddenly ran into superior enemy forces on the night of 12 March 1952. While aiding the wounded, Womack himself was hit. As he worked on, a mortar burst tore off his right arm. Even now he directed others in administering first aid to the wounded and was the last man to leave the scene. He soon collapsed from loss of blood and died a few minutes later in the arms of his comrades. Womack received the Medal of Honor posthumously, one of many who died in Korea's no-man's-land in actions little noticed by the world at large.²

Any hopes—millions entertained them—that the war might be nearing an end were dashed during these months. The Chinese and North Korean armies were in part composed of men who were not committed to their own governments, for the Chinese Army had absorbed many of its Nationalist opponents during the civil war of 1948–49 and the North Koreans had impressed both anti-Communists and unwilling South Koreans into their own ranks. As a result,

¹Rpt, Office of the Deputy Assistant Chief of Staff, DA, sub: Winter Combat Problems, Korea, December 1951–February 1952, Observations by Department of the Army Winter Environment Team, file 381 (Korea) F, 1951, Box 53, Accession no. 56A–179, RG 112, WNRC; Hermes, *Truce Tent and Fighting Front*, pp. 178–86. On nutritional problems of the South Korean troops, see Chapter 11 of this volume.

²Committee on Veterans' Affairs, *Medal of Honor Recipients*, p. 805.



AIDMEN HELPING CASUALTIES OF A PATROL MISSION

prisoners of war (POWs) held by the U.N. forces were sharply divided on whether to return home in the event a truce was reached. The United States moved reluctantly and with many hesitations to a position that only POWs voluntarily seeking repatriation could be returned. Though the Communist nations tried by every means to avoid actually saying so, this was unacceptable to them. Months of discussions during 1951 only served to sharpen the issue, and by January 1952 negotiations had reached a stalemate over a matter of substance on which neither side was disposed to give way.

In consequence, new battles broke out of singular ferocity and little practical effect—images in miniature of the great, futile struggles of the Western Front in World War I, when the combatants fought like beasts with locked horns, unable either to win or to let go. The fighting that began in May 1952 revolved around efforts of the 2d and 45th Infantry Divisions to gain and hold the heights called Old Baldy and Porkchop Hill near Chorwon, at the southwestern apex of the Iron Triangle. Here fighting was as savage as any since the war of movement had ended.³

³The following account is based on 2d and 45th Infantry Divisions, Annual Reports of Medical Service Activities, 1952, files 319.1-2 (2d Inf Div) and (45th Inf Div) Far East-1952, HRB. Quotations from 2d Division report, as follows: first, p. 6; second, p. 2; third, p. 5; fourth and fifth, p. 8. Another change of command occurred in May, when General Mark W. Clark replaced Ridgway as U.N. commander in Tokyo.



FORWARD AID STATION NEAR OLD BALDY

Evacuation took familiar forms. As usual, the helicopter proved to be invaluable in evacuating the seriously wounded and the hemorrhagic fever cases that continued to occur. The 45th Division surgeon strongly recommended incorporating some "choppers" into the division's medical battalion. Although the corps surgeons favored the proposal, the small number of machines made it impossible to carry out. Land vehicles continued to carry most of the wounded. Rail buses moved severe cases at night, and despite bad roads and heavy traffic, the wheeled ambulance remained the first reliance.

In contrast to earlier fights, improved forward treatment now had become the rule rather than the exception. In the 2d Division only a little over one-fourth of the battle casualties were evacuated out of the division area. Divisional facilities handled the rest and returned them to duty. The 2d Division surgeon identified the reason for his improved capability as the "static tactical situation" that enabled the clearing and collecting stations to dig into more permanent sites and freed the physicians of the need to be constantly preparing for the next move. He also cited the obvious advantages of the new system in holding onto manpower and saving the costs of evacuation.

One consequence of the forward buildup was a partial change in that most basic of Korean medical traditions, the primacy of transport. Encouraged by the static line that gave greater security to patients and medics alike, medical units moved "close to the wire," held their patients longer, and depended on the

excellent roadnet the engineers were carving out in the forward areas to concentrate casualties close behind the front. Battalions customarily maintained both forward and rear aid stations. The forward station was good for the morale of the fighting men and also reduced the exhausting litter carries that were so hard on the wounded and the men who bore them.

Forward of the main line of resistance where roads vanished and enemy fire was heavy, the armored personnel carrier won praise as an ad hoc ambulance. When September brought both a fierce Chinese counterattack on Old Baldy and heavy autumnal rains, other vehicles took up the task as well. Bridges washed out and roads were several feet under water in a large part of the 2d Division sector. Even tracked vehicles were unable to move under such conditions, but two vehicles familiar from World War II—the Weasel and the DUKW—took up the burden. Weasels were tracked cargo carriers that proved “rather ineffective” as conditions worsened, and the division surgeon called upon the Navy for the amphibious DUKWs. These craft “proved to be very effective,” both in carrying supplies into flooded areas and in bringing wounded out.

The psychology of position warfare reflected the conditions under which the men now lived and fought. Rotation brought in new and inexperienced soldiers, personnel turbulence was high, and men faced battle among strangers. All these conditions afflicted the 2d Division during its July battle. Even though the division had been long in Korea, its troops, by and large, were new and untried. The division’s psychiatrist reported that in some units a “serious breakdown in command” occurred due to combat losses and “poor leadership.” The ratio of neuropsychiatric cases to battle casualties reached a 1952 high of 1 to 3.6. However, with forward psychiatry now well established and with proper forward holding facilities, 80 percent were returned to duty. The contrast was striking in the later, equally bitter fighting against Chinese counterattacks. The ratio sank to 1 to 17, comparing favorably with the professional and veteran French Battalion’s 1 to 14.

These figures might have given some comfort to those asking the painful question of why Americans had so poor a record in enduring stress by comparison with the U.N. forces they fought beside. The Americans alone were draftees, and the operations of the rotation system virtually destroyed esprit de corps, the crucial feeling of identity with the unit that provided stable professional battalions much of their vitality and strength. Ironically, rotation came in during the autumn of 1951 just as the war was changing its character, a change confirmed as it settled into stalemate during 1952. Never had cohesive professional formations been more in demand than during a fight whose only possible aim was to restore the *status quo ante bellum*; never had the Army been farther from such stability. An important compensating factor was the advantage that the static front gave the maturing field medical service to repair some of the damage to morale wrought by continuing turbulence.

From Battle Line to Hospital

On the western part of the line, evacuation continued during 1952 in well-established patterns. The main innovation was the approach of the railroads



EVACUATION BY LITTER TOBOGGAN

ever closer to the fighting. In the central mountains occupied by the X Corps' 40th and 45th Infantry Divisions, which were federalized National Guard units, a precipitous landscape demanded greater ingenuity. Here a wounded man might travel his first few hundred yards down the south slopes on tramways or litter toboggans. Eighth Army ambulance companies provided transport from clearing stations to holding units at the airstrip, for in X Corps almost all evacuation out of the corps area was by air. The seriously injured rode by helicopter from battalion aid stations direct to the surgical hospitals, routinely (though not invariably) bypassing the collecting and clearing stations. Neurosurgical cases went to the 8209th MASH, where immediately they entered the specialized neurosurgical chain of evacuation. Though casualties of the Republic of Korea (ROK) Army divisions usually moved by Eighth Army ambulance or U.S. Army helicopter to their own hospitals (the ROK 6th MASH served the X Corps also), cases too serious for the Korean system were taken into U.S. hospitals instead.⁴

⁴X Corps and 40th Infantry Division, Annual Reports of Medical Service Activities, 1952, especially p. 12 and p. 21, respectively, files 319.1-2 (X Corps) and (40th Inf Div) Far East-1952, HRB.

The Eighth Army now sought to organize evacuation under a single headquarters, the 52d Medical Battalion. Activated in 1949 at Fort Benning, Georgia, the battalion at the beginning of 1952 was a floating headquarters located in Pusan with responsibility for medical regulating. It contained only two assigned units plus an attached collecting company, hospital train, and ambulance company. The train brought patients from the North; the ambulance company carried them from the railhead to the various hospitals crowded in and around the port city. The battalion also serviced the airstrip 9 miles outside the city, carrying patients to and from the planes and the hospital complex. But late in January the battalion headquarters moved to Yongdung-po near Seoul, setting up offices in four permanent buildings while the troops pitched tents for housing. Now the battalion began to grow like Topsy, acquiring fourteen new units during February. In effect it became a medical group charged with the evacuation of casualties throughout Korea. From the division areas back to Pusan and thence to Japan, U.N., ROK, and U.S. casualties rode ambulances or trains controlled by the battalion headquarters.

The basic plan adopted by a small organization with such extensive responsibilities was to attach an ambulance company to each corps area. Other units remained under battalion control, to be used as the tactical situation demanded. The 52d Medical Battalion's ambulance companies evacuated from division clearing stations to the MASHs; from the MASHs to the battalion clearing companies; and thence to railheads, where battalion trains took them on, or to air evacuation points. The hospital trains carried the wounded south to Taegu or Pusan where more of the battalion's attached ambulances carried them either to hospital ships in Pusan harbor or to an airstrip for transport to Japan.

In August, when the Korean Communications Zone (KCOMZ) was set up, all units under the 52d Medical Battalion that were south of a lateral line through Wonju passed to the control of the zone. The area between the Wonju line and the front remained under the battalion's control. Later, in the spring of 1953, the battalion itself would come under the control of the newly activated 30th Medical Group, the first to operate in Korea. In the meantime, it served as a sort of Eighth Army medical command, relieving the Army surgeon of much day-to-day operational responsibility for a melange of units and enabling him to concentrate on his duties of setting policy and advising the Army commander. Its size and lack of an adequate headquarters, however, made it both less independent and less useful than it might have been. Its orders were cut at the Eighth Army headquarters, and the Eighth Army surgeon apparently ran the battalion with his left hand.⁵

Another innovation, dating in this case from 1951, was the organization of rear medical units on an area basis. The Department of the Army ordered the Eighth Army surgeon to conserve physicians by eliminating the medical detach-

⁵52d Medical Battalion (Separate), Annual Report of Medical Service Activities, 1952, sec. 2, file 319.1-2 (52d Medical Bn, Sep) Far East-1952, HRB. See also Interv, Samuel Milner with Col Robert P. Campbell, MC (hereinafter cited as Campbell Interv), 18 Aug 66, AMEDD Oral History file (Campbell), HRB.

ments of separate units in favor of local dispensaries. He turned to a skeleton unit, the 163d Medical Battalion, to coordinate a change that medics on the scene found more of a burden than a help. Unit commanders felt little responsibility for medics who no longer belonged to their organizations and failed to provide for such needs as shelter, clothing, food, discipline, or personnel services. The battalion headquarters had little exact knowledge of the medical needs of a collection of engineer, ordnance, signal, and other specialized units, many operating in remote locations and constantly subdividing their personnel to carry out different tasks. Units moved; dispensaries stayed put. Fewer doctors met larger sick calls. Preventive medicine in units without organic medical support was neglected. If designed to generate a good deal of petty ill-feeling, the plan was a success.

In the end the solution was to “go 360°,”⁶ as a medical officer put it, attaching each dispensary to one of the units it served for administrative and logistical support. In many cases the end result was not distinguishable in any practical way from the organic medical support of times past, except that a great deal of diplomacy was required to define the rights and duties of commanders, medics, and the battalion headquarters. The primary advantage came in areas with large troop concentrations, where a single big dispensary could do the work of many unit medics, conserving medical strength and making skilled personnel available for other assignments. Whether the advantage was worth the bother was a question to which most officers involved still would have returned a negative answer.

Outside the control of the catchall battalions, the Eighth Army's hospitals also registered the changing nature of the war. When the KCOMZ took over the rear areas, many hospitals shifted to its control, including the 21st, 25th, and 171st Evacuation Hospitals, Semimobile, and the Swedish Red Cross Hospital. In all, during 1952 the Eighth Army's hospital resources shrank from seven evacuation hospitals to two (counting the Swedish hospital in this category) and from three field hospitals to none. The effect on actual field operations was, however, less important than it appeared. The evacuation hospitals already had acquired the functions of station hospitals supporting urban troop concentrations, and the field hospitals already were serving the POWs. The Eighth Army retained the six American and one Norwegian surgical hospitals. The Italian Red Cross Hospital, aiding the civilians of the Seoul–Yongdung-po area, kept its forward location but passed administratively to the KCOMZ. Two evacuation hospitals the 121st and 11th, remained with the field army—not enough, according to General Ginn, the Eighth Army surgeon, to support a return to a fast-moving tactical situation if the nature of the war changed again. Evacuation hospitals in the army area, like those in the communications zone, tended more and more to resemble station hospitals. Routine matters, including physical examinations and consultations, filled the wards and made the hospitals even less mobile than before. MASHs as well were allowed to dig in and to construct

⁶Campbell Interv, 18 Aug 66, HRB. In 1953 the 163d Medical Battalion, like the 52d Medical Battalion, joined the newly formed 30th Medical Group.



NURSE AT THE ITALIAN RED CROSS HOSPITAL *bathing the injured foot of a Korean child*

temporary buildings. General Ginn remarked that “few, if any, individuals on duty in any of our hospitals at the present time have seen the unit[s] moved.”⁷

If medical organization under the Eighth Army appeared to parallel broadly the developments in the KCOMZ, part of the reason was that evacuation from Eighth Army hospitals did not go automatically to the communications zone. Ginn wrote of “the two communications zones” that supported the field army, the KCOMZ and “Army Forces Far East, formerly the Japan Logistical Command.” The Eighth Army surgeon saw little advantage in sending his most serious cases to the KCOMZ. Instead, as in the past, his hospitals evacuated by air to Japan, which was closer in the sense that large cargo planes equipped to handle the sick and wounded on return trips flew direct to Tokyo and other Japanese cities. Hence, Ginn could write paradoxically that “due to their relative inaccessibility the evacuation hospitals in KCOMZ have been utilized by the Eighth Army primarily for the care of cases of disease and minor non-battle injury, and the short-term convalescence of minor battle wounded. They cannot be considered reasonably available for true evacuation hospital functions.” The KCOMZ took the overflow of minor cases from the field army but, because of the ubiquity of air transport, never became a communications zone in the

⁷EUSAK, Annual Report of Medical Service Activities, 1952, p. 5, file 319.1-2 (EUSAK) Far East-1952, HRB.

World War II sense of a stage through which all serious casualties passed on their way to definitive care.⁸

The growing sophistication of the Eighth Army hospitals helped to make the system workable. The Eighth Army hospitals were as well equipped and staffed as those further to the rear in Korea. Specialization continued to make progress. A center for the treatment and rehabilitation of neuropsychiatric cases grew up on the outskirts of Seoul in a cluster of tents and quonset huts staffed by the 212th Psychiatric Detachment and the 123d Medical Holding Company. Neurosurgical detachments worked at both the 8209th MASH and the 8063d MASH, serving respectively the eastern and the western parts of the front. In July a neurosurgical team under 1st Lt. Joseph C. Barnett, Jr., began to assist the front-line ROK Army hospitals. The success of the neurosurgical units in Korea led to issuance of a table of organization and equipment (T/O&E) with slots for three surgeons, a nurse, and three enlisted men, and for operating room equipment, a jeep, and a trailer. In other developments the 121st Evacuation Hospital became a center for the treatment of eye injuries and the 11th Evacuation Hospital, Semimobile, continued to work with kidney problems, notably lower nephron nephrosis resulting from blast injury. Research also continued in half a dozen fields, including cold injury and hemorrhagic fever.

Kidney research at the 11th Evacuation Hospital, which was located at Wonju, was the responsibility of the surgical research team. Working in a newly established renal insufficiency center, the team in March 1952 introduced a device new to Korea—the first artificial kidney machine at a forward hospital. Kidney dysfunctions often resulted from wounding, primarily as a consequence of low blood pressure caused by bleeding. The inability of the kidneys to maintain an adequate urinary output was associated with shock, through the severe failure treated by the kidney machine (oliguria or anuria) was rare. Both a means of tiding over severe surgical cases and a tool for studying the general problem of kidney lesions in war casualties, the machine proved a useful tool. Though about two-thirds of the very serious cases who received dialysis died, more than 90 percent of similar cases had perished during World War II.⁹

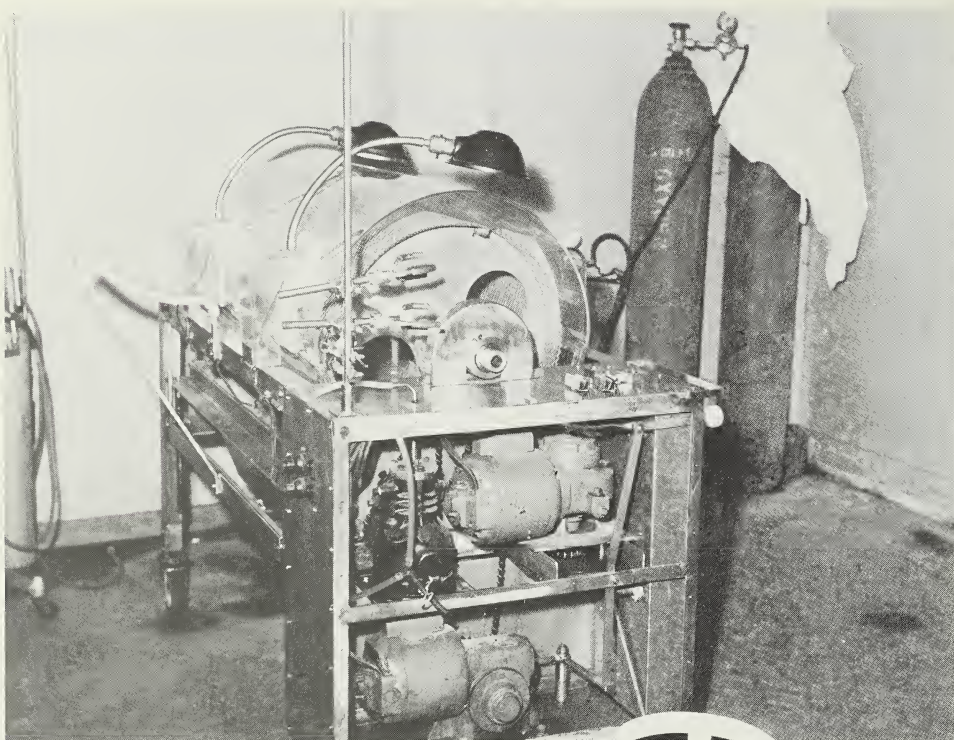
The most outstanding forward-area clinical innovation of 1952 was the rapid improvement in arterial repair.¹⁰ During World War II severely damaged peripheral arteries normally were ligated (tied off). Both doctor and patient then waited to see whether smaller satellite vessels could supply blood to the limb in sufficient quantity to preclude amputation.

⁸Quoted words from *ibid.*, annex IV, p. 27, HRB. See also EUSAK, Report of ETMD, August 1952, pp. 14–16, file 350.05 (EUSAK) 1951, HRB.

⁹Howard, *Battle Casualties in Korea*, 4:1–6, 42; EUSAK, Annual Report of Medical Service Activities, 1952, annex IV, pp. 11–13, HRB; Army Medical Service, *Neurological Surgery of Trauma*, pp. 18–19; 8086th Army Unit, Military History Detachment, “Surgical Hospital in Korea,” Ms no. 8–5.1A DN, RG 319, MMHB; 11th Evacuation Hospital, Semimobile, Annual Report of Medical Service Activities, 1952, pp. 18, 22, file 319.1–2 (11th Evacuation Hospital, Smb) Far East–1952, HRB. The 3d Neurosurgical Detachment was organized at the 8063d MASH in April 1952. The 140th Neurosurgical Detachment, at the end of June, absorbed and expanded Meirowsky’s team at the 8209th MASH. On the surgical research team, see below.

¹⁰Sources for the following section include: FEC and USAFFE, Annual Report of Medical Service Activities, 1952, p. 40, file 319.1–2 (FEC) Far East–1952, HRB; Report of Research Team for Medical Investigation in the Field, prepared by Fiorindo A. Simeone, M.D., et al., July 1951, Encl to

(Continued)



ARTIFICIAL KIDNEY MACHINE at the 11th Evacuation Hospital

But about half of all World War II arterial wounds of the extremities ended in loss of a limb. The situation in Korea appeared more hopeful, for the introduction of the helicopter opened new possibilities. Deterioration of the wounded limb was a function, among other things, of the time that elapsed between arterial injury and repair. Because such injuries received priority for helicopter evacuation, the average time dropped below a critical figure that most surgeons set at about ten hours. Besides the helicopter, advances in surgical technique also had occurred since World War II, notably in the use of arterial segments taken from corpses that were preserved in an antibiotic solution and grafted into

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Memo, Simeone et al. to Col William S. Stone, MC, Commandant, Army Medical Service School, 27 Aug 51, sub: Report of Research Team for Medical Investigation in the Field, file 333 (Far East Command) AA, 1951-52, and Ltr, Maj Gen William E. Shambora, Chief Surgeon, Medical Section, FEC, to Maj Gen George E. Armstrong, Surgeon General, DA, 10 Jun 52, file 319.1 (Far East Command) AA, 1951-52, both in Box 69, Accession no. 56A-179, RG 112, WNRC; Carl W. Hughes, "Acute Vascular Trauma in Korean War Casualties," *Journal of Surgery, Gynecology, and Obstetrics* 99 (July 1954): 91-100; *ibid.*, "Arterial Surgery During the Korean War," *Annals of Surgery* 147 (April 1958): 555-61; Edward J. Jahnke, "Late Structural and Functional Results of Arterial Injuries Primarily Repaired," *Surgery* 43 (February 1958): 175-83; Frank C. Spencer and Roy V. Grewe, "The Management of Arterial Injuries in Battle Casualties," *Annals of Surgery* 141 (March 1955): 304-13; Noble S. R. Maluf, "Use of Veins in Surgery: A History," *Sudhoffs Archiv, Zeitschrift fuer Wissenschaftsgeschichte* 67 (1983): 50-73.

large gaps. Both transport and surgery, therefore, promised advances on the record of the previous war.

During 1950 and 1951, however, the surgeons failed to seize their opportunity. In mid-1951 a field research team reported that wounds of arteries continued to be "life-endangering as well as limb-endangering lesions."¹¹ Apparently most, as before, were treated by ligation, with consequences much like those in times past. Accurate information on the results of treatment, or even on the number of cases, was hard to come by because of rapid evacuation, overwork, hasty record-keeping, and high personnel turnover. Efforts at the 8055th MASH to suture the ends of severed arteries (end-to-end anastomosis) showed little improvement over ligation. Attempts to replace sections of damaged arteries with homologous grafts from corpses, or with autogenous vein grafts from the patient's own body, seemingly failed whenever tried. Because the patients arrived after a lapse, on average, of a little over nine hours since wounding, time was not the problem. What was needed was instruction in improved surgical technique. Beginning in April 1952, this was supplied, notably by Lt. Col. Carl W. Hughes working at the 8055th MASH, and by the surgical research team, which, under Capt. John M. Howard, was engaged in studying many of the complex bodily changes which resulted from wounding. Maj. Edward J. Jahnke of the Medical Corps, sent to Korea from Walter Reed for thirty days, lingered twice as long to teach methods of vascular repair.

In 1952–53 vascular surgery at the MASHs demonstrated the value of anastomosis when only short sections of arteries required repair, as well as the superiority of autogenous vein grafts over homologous arterial grafts. Between April 1952 and the end of the war 269 of 304 major arterial injuries were repaired and only 35 ligated. The failure rate dropped to 15 percent, or less, though the final results were somewhat more difficult to summarize. Follow-up studies showed lingering problems in the repair blood vessels, yet many limbs that ligation would have left only partly useful regained full function. Overall, arterial repair after the spring of 1952 was one of the more striking success stories of military medicine in Korea, in Marine Corps as well as Army hospitals. Limbs that would have become gangrenous only a few years earlier were saved from the knife.

Life on the Line

The maturing of the medical system took the most varied forms. For medics in general, comfort and safety in their daily lives improved markedly. Compared to aidmen, litterbearers, and jeep ambulance drivers who continued to face danger in their jobs on the line, many medics—especially those in hospitals—encountered fewer risks. Statistics for 1952 indicated that no medical officers and only two Medical Service Corps officers were killed in action. Food was ample, with three hot meals a day served at company headquarters and

¹¹Report of Research Team for Medical Investigation in the Field, Simeone et al., July 1951, Encl to Memo, Simeone et al. to Stone, 27 Aug 51, RG 112, WNRC.

battalion aid stations. Most medical companies operated a PX. Unpleasant duties and heavy manual labor fell to Korean civilians hired for the task, or to the Korean Service Corps personnel (KSCs). At the MASHs during late 1951 and 1952 baseball diamonds appeared on level spots, horseshoes clanged, and volleyball teams practiced. On summer days swimming parties visited "clear pools formed by mountain streams." As danger lessened, the surgical hospitals gained a reputation for insouciance bordering on wackiness. Liquor was abundant and cheap, and the MASH was normally the farthest point forward that American women got in Korea. Questioned about the nature of the hijinks during off-duty hours, a MASH doctor later said tersely, "Oh, sex and liquor. What else is there?"¹²

With such relaxation went, very often, an unmilitary slackness that reflected both the nature of the war and the outlook of doctor draftees. Inspections of medical installations in the X Corps during September 1952 showed that poor appearance and absence of spirit were the rule. "Mess halls and kitchens were disorderly and unattractive. Equipment and supplies were poorly segregated, stored, and maintained. Police was poor. . . . There was no unit pride. . . . The standards usually expected of medical units and installations were not, in general, being maintained." The military, as opposed to the professional, training of the medical officers was "generally poor." Pulled from budding practices and thrust by their lack of rank to forward stations in an uninviting land, young doctors displayed unconscious arrogance and a refusal to adapt to the necessities of a life that they despised. Such men failed to understand their responsibilities in respect to "equipment, maintenance, supplies, records, reports, training of enlisted personnel, and other non-technical activities. . . . A deep sense of responsibility toward the military service seems never to have been gained."¹³

As a result, even their professional skills sometimes showed poorly, in part because their enlisted subordinates either did not know or did not practice their jobs. Enlisted men showed a lack of courtesy, looked unmilitary, maintained equipment in a slipshod manner, and expected their failings to be overlooked or condoned. In the X Corps aidmen handled casualties roughly, leaving them exposed to weather; litterbearers sometimes ran with patients or walked backward; and drivers operated their ambulances at excessive speeds. Officers and enlisted men alike were ignorant of, or indifferent to, basic administrative tasks. The corps surgeon blamed the emphasis on professional and technical subjects to the detriment of field training. How much complaints of this nature reflected an unbridgeable difference in style between civilian and military and how much they represented actual failings on the part of the former is impossible to determine. Both elements were certainly present.

Judged by the only standard that ultimately mattered, the saving of lives, the draftees did as well as their predecessors. The MASH of 1952 had become a matured practitioner of emergency medicine in a style that civilian practice was

¹²First quotation from 8209th MASH, Annual Report of Medical Service Activities, 1951, p. 4, file 319.1-2 (MASH, 8209th Army Unit) Far East-1951, HRB. Second quotation from confidential communication to author.

¹³X Corps, Annual Report of Medical Service Activities, 1952, pp. 29-30, HRB.



TYPICAL MASH OPERATING ROOM

not to see widely employed for another fifteen to twenty years. The total system—including attached helicopters, corpsmen to act as paramedics, and advanced methods of treating shock—was the key to success. In August 1951 the MASHs had briefly experimented with special shock treatment sections, only to abandon them because the sections found too little to do between battles. (Such dedicated units, however, existed in evacuation hospitals where the staff was larger.) Instead, the MASH's preoperative section prepared casualties for surgery, acted as a shock treatment unit, and in slack times ran an outpatient clinic as well.¹⁴

Amid technical innovations and changes of personnel, one thing that did not change was the MASH's basic function of performing what Capt. H. Richard Hornberger of the 8055th later called "meatball surgery." Speaking as Richard Hooker, pseudonymous author of *M*A*S*H*, he suggested that

meatball surgery is a specialty in itself. We are not concerned with the ultimate reconstruction of the patient. We are concerned only with getting the kid out of here alive

¹⁴8055th MASH, Annual Reports of Medical Service Activities, 1951 and 1952, pp. 3–4, 16–17 and pp. 2–3, respectively, files 319.1–2 (MASH, 8055th Army Unit) Far East–1951 and 1952; 8228th MASH, Annual Reports of Medical Service Activities, 1951 and 1952, p. 3 and p. 6, respectively, files 319.1–2 (MASH, 8228th Army Unit) Far East–1951 and 1952. Both in HRB. See also 8086th Army Unit, Military History Detachment, "The Regimental Medical Company in Korea," Ms no. 8–5.1A DO, RG 319, MMHB.

enough for someone else to reconstruct him. Up to a point we are concerned with fingers, hands, arms and legs, but sometimes we deliberately sacrifice a leg in order to save a life, if the other wounds are more important. In fact, now and then we may lose a leg because, if we spent an extra hour trying to save it, another guy in the preop ward could die from being operated on too late. . . . Our general attitude around here is that we want to play par surgery. Par is a live patient.¹⁵

On the operating table "par surgery" did not permit elegant technique. In suturing the four layers of the bowel, a surgeon from Georgia was not "quite as dainty" as the replacement he was instructing. "I've got mucosa to mucosa, submucosa more or less to submucosa, muscularis pretty much to muscularis and serosa to serosa, and there ain't any place where it's gonna leak. It took y'all two hours, and it took me twenty minutes." Despite growing stability and sophistication and a general decline in the proportion of wounded to sick, brusque and rapid lifesaving technique remained the primary function of the MASH. When battle wounded flooded in, the ability to work quickly was still the most basic of skills.¹⁶

Men in Armor

During the fighting of 1952 new equipment of considerable medical significance appeared on the line. Small laboratories at the clearing companies further strengthened divisional medical capabilities. Insulated casualty bags greatly increased the comfort and aided the survival of evacuees, especially as autumn came on and the weather turned colder. Among new items provided for winter wear were insulated footwear ("Mickey Mouse boots"), which proved to be vastly better than the shoepac. The boots were distributed, six thousand pairs to each division, between November 1951 and February 1952 and won instant popularity among the men who received them. The Jamesway, a weather-tight insulated tent stretched over a semicylindrical frame, proved a rugged, easily assembled means of housing the ill and wounded, cooler in summer than conventional tents and warmer in the winter.

But body armor was undoubtedly the premier innovation from the viewpoint of medic and front-line soldier alike. It transformed the medical statistics of the war by making chest and abdominal wounds rarer, peripheral wounds proportionately more common. Its use was so closely interwoven with the defensive psychology of static warfare as to make it almost a symbol of the new GI, who, lacking the enthusiasm and clear objectives of World War II, calculated his own victory in terms of personal survival.¹⁷

Experiments with body armor had taken place during World War II, leading to development of the "flak jacket" for fliers. Layers of fiberglass laminated by means of a resin formed a light, resistant material called doron. Though the new

¹⁵Hooker, *M*A*S*H*, p. 160.

¹⁶*Ibid.*, p. 159.

¹⁷2d Infantry Division, Annual Report of Medical Service Activities, 1951, pp. 10–11, file 319.1–2 (2d Inf Div) Far East–1951, HRB; Rpt, Office of the Deputy Assistant Chief of Staff, DA, sub: Winter Combat Problems, Korea, December 1951–February 1952, p. 59, RG 112, WNRC.

new armor proved highly effective in slowing missiles, commanders usually had rejected it as burdensome and inefficient and fighting men had ridiculed it. During June–October 1951, however, a joint Army-Navy medical team, headed by Lt. Col. Robert H. Holmes of the Medical Corps, visited Korea with a supply of 40 Navy armored vests to test the reaction of the front-line troops. The vests met an enthusiastic reception among officers and men alike, and the team recommended adoption of body armor as regular organization equipment. Extensive testing began the following March. Each division subsequently received about 350 vests to equip units going on patrol. So encouraging were the results that use among men on the line rapidly became as common as the number of available vests would allow. The marines were the first to be equipped, and the Army procured 25,000 of the Navy type and only 5,000 of its own, in recognition of the Navy vest's greater stopping power and the consequent preferences of the troops. (The Navy model provided a snug fit and doron plates covering the lower chest, back, and abdomen.)



INFANTRY SOLDIERS IN
ARMORED VESTS

Speculating on the reason for this change from World War II attitudes among American fighting men, the Army's 1952 body armor investigation team pointed out that "the action in Korea is unique in our military history in that the lack of specific battle goals and the prolonged truce talks [have] resulted in a feeling of caution in all combat echelons. Commanders, under these conditions, are not quite so ready to sacrifice personnel on the battlefield." Of the practical effectiveness of the armor there was no doubt. Armor cut the number of chest and upper abdominal wounds by 60 to 70 percent, and reduced the severity of one-fourth of those that did occur. Improved technology and Korean War psychology worked together to make the armored soldier, for the first time in American wars, the battlefield norm. A historian noted that "next to his weapons, the most important item to the infantry soldier was his armored vest."¹⁸

¹⁸Quoted words from Carl M. Herget et al., "Wound Ballistics and Body Armor in Korea," in *Wound Ballistics*, Medical Department, United States Army, ed. James C. Beyer (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1962), p. 743. See also Rpt, Joint Army-Navy Mission, Council of Medical Research and Development, OSG, sub: Medical Project—Body Armor, Korea, 14 June to 13 October 1951, prepared by Lt Col Robert H. Holmes, MC, et al., file 422.3 (Korea) F, 1951; Rpt, Body Armor Test Team, Office of the Assistant Chief of Staff, G-4, DA, sub: Report on the Use of Body Armor in Combat, Korea, February 1952–July 1952, prepared by Lt Col William W. Cox, MC, et al., September 1952, file 422.3 (Korea) F, 1952; and Memo, Deputy Chief, Medical Statistics Division, OSG, to Chief, Research and Development Division, OSG, 4



MAP 5

Back to the Battle

September and October brought new fighting as the two armies disputed for favorable terrain. In several of these battles the ROK Army demonstrated a new maturity, beating off heavy Chinese and North Korean assaults. American and U.N. units also were engaged. Enemy attacks, worst in the western and central sectors (*Map 5*), spread to the east, provoking attempts by U.N. forces to regain the initiative. Troops of the 31st Infantry of the 7th Infantry Division moved out in Operation SHOWDOWN to seize enemy positions in the bloody hills north of Kumhwa. Here a complex of heights and ridges centered on the triangular mass of Hill 598 formed the stronghold of crack Chinese troops of the *45th Division, Fifteenth Army*. Medical planning had to take into account the enemy's year-long efforts to fortify his position; the growth of enemy strength since the start of the armistice talks; and the powerful supporting fire of artillery and mortars. The landscape, as shown by aerial photos, was almost devoid of trees—a stark, dissected pattern of skeletal ridges.¹⁹

The 7th Division was similarly dug in, its battalion aid and regimental collecting stations in sheltered bunkers strengthened with sandbags and log roofs and walls. The 8063d MASH stood 9 miles to the rear of the 7th Medical Battalion, considerably closer than in the recent past. During late 1951 and early 1952 battle experience had compelled the medics to shift much basic surgery forward to the clearing station. Now, reduced to a formula by General Ginn, the new practice became a policy that received its first full test (and some important modifications) in SHOWDOWN.

Aiming to make the medical system more responsive to the needs of position warfare, Ginn decided that cases with minor wounds were either to be retained in the division area or moved by ambulance direct to an airhead and then to the evacuation or the rear hospitals. The moderately wounded were to be given supportive treatment in the clearing station and then evacuated from rail- or airhead to the evacuation hospital for definitive surgery. The critically wounded were to go direct from the battalion aid station to the MASH, by helicopter if possible. MASHs were to work at a central location in each corps area, serving several divisions as before. They kept a variety of other functions, such as providing primary hospitalization for nondivisional troops. For the time being they also retained their holding capacity of two hundred, with additional nurses and support personnel.²⁰

(Continued)

Dec 53, sub: Battle Casualty Data for Korea, file 704.1 (Korea) F, 1953. All in Box 54, Accession no. 56A-179, RG 112, WNRC. See also Ltr, Maj Gen William E. Shambora, Chief Surgeon, Medical Section, FEC, to Maj Gen George E. Armstrong, Surgeon General, DA, 22 Aug 52, file 319.1 (Far East Command) AA, 1951-52, Box 69, Accession no. 56A-179, RG 112, WNRC. The developments of the Navy vest is recounted in Bureau of Medicine and Surgery, *History of the Medical Department of the United States Navy*, pp. 111-16.

¹⁹Evidently, some GIs saw a different landscape, for one of the heights involved in the fighting was nicknamed Jane Russell.

²⁰Surgeon's Circular Letter 7, no. 1, Medical Section, FEC, 1 Jan 52, p. 3, file 300.5 (Circular Letters) FEC, HRB; 2d End, Headquarters, EUSAK, to Commanding General, FEC, 6 Dec 52, file

(Continued)



HOLDING WARD IN A REGIMENTAL COLLECTING STATION

Elements of two battalions, each supported by its medical platoon, moved forward in simultaneous and coordinated assaults. The battalions were drawn from the 31st and 32d Infantry regiments, whose medical companies took charge of evacuation from the aid stations back to the collecting stations. Because the attack was limited and distances short, aid stations, instead of advancing with the troops, were dug into bunkers in two narrow defiles through which assault troops would pass to attack the hill. Medics correctly anticipated that the most difficult leg of evacuation would be the first. They knew from hard experience that casualties would be much heavier than Army doctrine anticipated, and that the six litter squads authorized by each medical company's T/O&E would have to be supplemented by KSCs. Seven M39 armored personnel carriers (APCs) were obtained, to carry wounded back to the aid stations after bringing ammunition and supplies forward. The 31st Infantry was able to weld external litter racks on some of the APCs. (Even severely wounded men had to be removed from their litters if enemy fire compelled them to be carried inside, for

(Continued)

300 (Administration Classified from 13 Aug 52), Box 3133 (Medical Section, FEC), RG 338, MMFB. General information on the H 598 battle, unless otherwise cited, is in 8086th Army Unit, Military History Detachment, "Medical Planning and Support of Attack on H 598, 14 to 25 October 1952," Ms no. 8-5.1A DL, RG 319, MMHB. For a sharp critique of the new policy, see the comments of Bolibaugh, attached to 8086th Army Unit, "Surgical Hospital in Korea," RG 319, MMHB.

litters would not fit into the personnel carriers.) Helicopter landing sites were established south and east of Kumhwa, beside the advanced collecting stations. With these resources, and with personnel shortages that amounted in the 31st Infantry's medical company to 12 percent of the enlisted men, one doctor and five Medical Service Corps officers, the medics prepared for the attack.

Farther to the rear, the new policy brought a separate organization, the 618th Medical Clearing Company, to the railhead to receive all casualties who did not require immediate surgery at the MASH. Four helicopters of the Helicopter Detachment, 8191st Army Unit, waited at the MASH. By sunrise on 14 October the double envelopment of Hill 598 was under way.

Almost at once trouble developed. The Chinese fought back fiercely, hurling hand grenades, satchel charges, and pipe bombs down the slopes. On the high points that were won, heavy enemy counterattacks developed, intensifying after Hill 598 fell on the fifteenth. What had begun as a limited operation entrusted (in the original planning) to a single battalion, and later to parts of two, turned into a lengthy battle. As enemy artillery zeroed in, small arms and grenade-fragment wounds ceased to typify battle injuries. The massive tissue damage and extensive trauma of blast injury and shell fragments became common. On the first day of the attack, 3 percent of the approximately 330 casualties were critically wounded; on the second, with about the same number of casualties, 15 percent.

Company aidmen again proved themselves despite often inadequate training. In Ginn's opinion, the aidmen "can be credited with a greater salvage of manpower than the surgical hospital."²¹ Notwithstanding Ginn's efforts to relieve the MASH, it was crowded with patients waiting for surgery, obliging the Eighth Army surgeon to order debridement to be done at the clearing station and to add anesthesia equipment to its table of equipment. On 26 October, having beaten off the enemy attacks and gained its objectives, the 7th Division turned over Hill 598 to the ROK Army. Chinese attacks then promptly regained the height.

Twelve days of heavy fighting left over 1,400 men with battle wounds. Total casualties of all types totaled over 2,000. The two regimental medical companies themselves lost 4 killed and 50 wounded. After-action interviews revealed a complex picture of failure and success, of courage and cowardice. In the beginning medics simply disregarded field manual predictions of 3 to 5 percent casualties for small unit actions and prepared for 75 percent casualties in the assault units—a prediction amply confirmed when the 31st and 32d Infantry regiments together took 784 casualties out of about 1,000 men engaged. Veteran surgeons could compare such losses only to Iwo Jima. The heavy casualties and the harsh precipitous landscape combined to throw an intolerable burden on the enlisted litterbearers, for whom supplements were hard to find. Capt. Philip W. Heuman, regimental surgeon of the 32d Infantry, described how wounded, when they fell, "would often roll into deep ravines, some impossible to reach." Those who were brought out had to be strapped to litters, while the litterbearers held on and let them slide down the sloping ground. "It was a common occur-

²¹EUSAK, Annual Report of Medical Service Activities, 1952, annex IV, p. 20, HRB.



ARMORED PERSONNEL CARRIER EVACUATION *to an aid station near Hill 598*

rence for patients to arrive at an aid station on a litter filled with gravel and rocks.” Such journeys were made under constant mortar and artillery fire.²²

Men able to handle a task so perilous and physically demanding were hard to come by. Reliance on the KSCs usually was ill-placed. These men, rejects from the ROK Army, were understandably terrified by the experience of battle into which they were forced without armor. “I have seen them,” said a surgeon, “sent out under fire without any protection, not even metal helmets . . . controlled by soldiers who brandish their weapons” to force them on. Treated as outcasts, the KSCs responded accordingly. KATUSAs, on the other hand, treated with greater respect and supplied armor, usually won praise for their performance. In spite of these efforts, the medical system’s weakest link in its chain of evacuation was still the first. The problem of getting the casualty to the battalion aid station had not yet been solved.

The overwhelming influx of wounded also astonished and disoriented inexperienced junior surgeons. The first twenty-four hours of the battle found them at their worst. “They seemed,” said a regimental surgeon, “unable to perform the definitive forceful treatment required, but instead spent their time piddling.” Yet learning came quickly, and after the first day most were performing

²²Quotations in this and the following two paragraphs from 8086th Army Unit, “Medical Planning and Support of Attack on H 598,” pp. 43, 75, 80, RG 319, MMHB.



PREPARING A CASUALTY FOR EVACUATION BY TRAMWAY

tasks of great importance to the patient: tracheotomies to open blocked airways; abdominal wall punctures to drain fluid; wound explorations to control major arterial bleeding; and nerve blocks to suppress pain. Abundant supplies of whole blood permitted massive transfusions in the later stages of the fighting.

At times the forward aid stations were scenes of half-controlled chaos. Sweating Korean laborers hauled litters in at gunpoint. Stragglers and walking wounded wandered in by themselves and preempted litters needed for more serious cases. Medics stripped the wounded, tossing clothes and armored vests alike onto growing piles of ruined equipment. Sometimes they turned up grenades with half-pulled pins. At the collecting stations helicopters proved impossible to call because enemy artillery had destroyed the phone lines, and only a few of the wounded were evacuated by chopper during the battle. As yet, the new medical system had more problems than successes to report.

Germ Warfare

While the pattern of static warfare matured on the line, a new and bizarre element appeared in the war of words between Communist and non-Communist blocs. The Chinese and North Koreans launched a massive effort to convince their own people and mankind at large that the United Nations Command was

engaged in the widespread use of biological weapons. Except in its earliest days, the germ warfare campaign was not a purely medical story. Yet it originated in a medical emergency and retained to its end strong medical overtones.

Stories of combatants waging war by the deliberate dissemination of disease have appeared through much of recorded history. A medieval chronicler told the tale that the Black Death entered Europe in the fourteenth century after Tartars, besieging a city on the Black Sea, catapulted the corpses of plague victims over the walls. Fleeing Genoese seamen then carried the disease to Italy. Similar stories exist in American history of colonists or British soldiers giving the blankets of smallpox victims to Indian tribes with malicious intent. Documenting such charges is far from easy. During World War II the only power to employ germ warfare was Japan, whose forces in Manchuria apparently undertook "field trials" against the Chinese. In the American Army suspicion and dislike of biological weapons were rife in the Medical Department, though medical officers were assigned to the installations of the Chemical Warfare Service where such weapons were developed and tested. Reflecting on the war-time experiments carried out in the laboratories at Camp Detrick, Frederick, Maryland, and elsewhere, Brig. Gen. Stanhope Bayne-Jones of the Medical Corps, who had observed the program, judged the results "all very interesting and as alarming as you want to make it, and as foolish as you want to make it. . . . Nobody knew what actually was practical. . . . The philosophical and moral problems were very difficult of solution."²³

The Japanese germ warfare experiments were of great importance not only in shaping the views of Asian Communists but also in raising early and durable suspicions of Americans. At Pingfan, near Harbin, Manchuria, a unit of the Kwantung Army under Lt. Gen. Shiro Ishii conducted experiments on prisoners that were morally comparable to those in Nazi concentration camps, for which German war criminals were tried and, in some cases, executed. However, decisions at a high level of the American government prevented similar action against Ishii and his subordinates. In 1947 experts working for the State-War-Navy Coordinating Committee, which communicated American policy directives to SCAP, termed the results of Ishii's work "of great value in confirming, supplementing and complimenting several phases of U.S. research. . . ." With the aim of securing Ishii's information and denying it to the Russians, American officials failed to prosecute him for war crimes. Yet the story of the Pingfan experiments came to light. At the war crimes trials in Khabarovsk the Russians tried and convicted a number of Japanese soldiers who had participated. Testi-

²³Quoted words from Interv, Harlan B. Phillips with Stanhope Bayne-Jones, 1967, p. 520, Bayne-Jones Collection, National Library of Medicine, Bethesda, Md. The story summarized here has been told at greater length and from a somewhat different viewpoint in Albert E. Cowdrey, "'Germ Warfare' and Public Health in the Korean Conflict," *Journal of the History of Medicine and Allied Sciences* 39 (April 1984): 153-72. See also Memo, Norbert H. Fell, Chief, PP-E Division, Camp Detrick, to Chief, Chemical Corps, 20 Jun 47, sub: Brief Summary of New Information About Japanese B.W. Activities, Biological Warfare Laboratory Collection, Fort Detrick Archives, Frederick, Md.; Msg, CINCFE C-52423 to WDGID, 6 May 47, file 107-0, Box 1519 (War Crimes Branch, International Affairs Division, JAG, 1944-49), Entry 143, RG 153, MMFB; John Norris, "East or West? The Geographic Origin of the Black Death," *Bulletin of the History of Medicine* 51 (Spring 1977): 11; *Materials on the Trial of Former Servicemen of the Japanese Army Charged With Manufacturing and Employing Bacteriological Weapons* (Moscow: Foreign Languages Publishing House, 1950), p. 23.

mony about the Ishii unit and its use of insect vectors in biological warfare filled the published record of the trials.²⁴

At the time of the Korean War, accusations against Ishii and efforts to force SCAP to bring him to trial formed a continuing theme of propaganda by Asian Communists. Chinese, North Korean, and Russian newspapers repeatedly called attention to the Ishii episode. "During World War II," reported Hsin-hua, the official Chinese news agency in 1951, "the Japanese army used bombs with bacteria of bubonic plague and typhus after their invasion of northern and central China. . . . After the defeat of Japan the war criminals enjoyed MacArthur's protection and were not punished." From this it was not far to the fictional elaboration that "US authorities assigned Ishii Shiro, leading Japanese bacteriological warfare expert, to develop bacteriological weapons to be used against us, instead of punishing him as a war criminal."²⁵

The bitter fighting in Korea soon raised the specter of germ warfare. Stories alleging its use by the United Nations Command appeared in the press of Communist nations, randomly intermixed with other atrocity stories. Americans shared the climate of opinion with their adversaries. During October 1950 men of the 7th Division saw two Koreans throw a "brownish powder" into a stream in their bivouac area in North Korea. A release by the division's public information officer spread the story that "several fish rose to the surface," presumably dead.²⁶ Some of the powder was secured and sent for analysis to Japan. There the medical laboratory found it to be plant debris, its only microbes normal field contaminants. Apparently the powder was an herbal preparation used by peasants to stun fish. Concern was sufficient, however, to bring a special technical intelligence team into the picture, to check this and similar allegations, and experiments with the brown powder continued for a time in the United States.

Later in the month, when U.N. troops entered the North Korean capital of Pyongyang, germ cultures from the Kim Il Sung Medical College were subjected to similar examination. Interrogators questioned personnel of this and other North Korean laboratories, with an eye to discovering military influences on

²⁴Quoted words from Draft Rpt, E. Wetter and H. I. Stubblefield, sub: Interrogation of Certain Japanese by Russian Prosecutor, p. 2, Encl to Memo, Comdr J. B. Cresap, Secretary, State-War-Navy Coordinating Committee, to R. A. Fearey et al., 1 Jul 47, same sub, file 107-0 Box 1519 (War Crimes Branch, International Affairs Division, JAG, 1944-49), Entry 143, RG 153, MMFB. See also Statements by Maj Gen Kiyoshi Kawashima and Maj Tomio Karasawa (Document nos. 9305, 9309, 9306), Encls to Ltr, Chief, Legal Section, SCAP, to Civil Affairs Division, War Crimes Branch, DA, 30 Jun 47, sub: Transmittal of Affidavits, file Legal Section, SCAP, Admin Correspondence, Box 1 (Admin Correspondence, 1945 to 13 Jun 52), Entry 271, RG 331; and related interrogations in file 330, Box 1736 (Investigation Reports, 1945-49), Entry 271, RG 331. All in MMFB. An American expert termed Japanese experiments with fleas "excellent." See Memo, Fell to Chief, Chemical Corps, 20 Jun 47, Fort Detrick Archives, Frederick, Md.

²⁵Quoted words from Peking *Jen-min Hih-pao*, 7 Mar 51, and Hsin-hua report in Prague *Svobodne Slavo*, 24 Mar 51, both in Central Intelligence Agency (CIA), Foreign Documents Division, "A Report on Foreign Press Coverage of Anti-US CW (and BW) Propaganda," 2 Jul 51, pp. 6 and 18, Report no. U-1378, CIA Archives, Rosslyn, Va.

²⁶Ltr, Lt Col R. L. Hullinghorst, MC, Commander, 406th Medical General Laboratory, to Surgeon, Japan Logistical Command, 18 Oct 50, sub: Biological Warfare Agent, Encl to Ltr, Maj Gen Edgar Erskine Hume, Chief Surgeon, FEC, to Surgeon, EUSAK, 20 Oct 50, sub: Report of Analysis of a Suspected Toxic Agent, file 312.3 (EUSAK Correspondence, 1-25 Oct 50), Box 3105 (Medical Section, FEC, General Records, 1950), RG 338, MMFB.

their work, possible Russian interest and assistance, and progress made in culturing plague and other pathogens. The only apparent positive finding was a remark by Dr. Yang Chang Fah that he could start an epidemic of Japanese B encephalitis "if I had the mosquitoes." One interrogator asked, "Do the Russians know you could start an epidemic?" "Yes," replied Dr. Fah, "they are very interested." The investigation, however, led only to the conclusion that no basis had been found for suspecting germ warfare activity in North Korea. Despite the appearance of some sensational stories in the Western press, the United Nations Command treated the matter as an intelligence question, to be decided on a factual basis.²⁷

On the other side of the battlefield, the Communist press gave increasing coverage to germ warfare stories in the months that followed. The reason for the heightened interest surely lay in the frightful conditions of Korea in the late winter and the early spring of 1950–51. With epidemics out of hand, propagandists in search of atrocity stories gradually abandoned earlier charges of gas warfare and began to focus on biological warfare instead. On 22 March 1951 a Shanghai report had MacArthur buying bacterial "media" from the government of Japan for use against the North Korean Army and people. (The procurement of Japanese vaccines was probably the germ of truth, so to speak, in the story.) A few days later a Canton newspaper quoted former Secretary of Defense Louis Johnson on the American budget for biological weapons, alleging that they were intended for use in Korea. Echoes of these stories resounded in apparently random fashion through the Eastern bloc, for editors there resembled their Western counterparts in their habit of filling space by copying other newspapers. Soviet press reaction was slight.

In China, however, the line began to get more vigorous play, with some evidence of a high-level decision to push it. In the first week of May the Chinese Red Cross protested against American use of captured Chinese in germ warfare experiments. The source of this charge was General Sams' lab-equipped landing craft in which he had visited the North Korean shore. The American magazine *Newsweek* published a story on the ship, and the Chinese seized upon the report as evidence that plague was being, not investigated, but deliberately spread. In Poznan, Poland, a garbled report communicated the news that "General Sam Crawford had been appointed to organize 'centers for bacteriological experiments' in Korea. . . . The American imperialists are so brazen that they no longer strive to hide their crimes." In Russia, *Pravda* and *Izvestiya* picked up the theme. Though the sensational reports spread widely, signs of an integrated worldwide propaganda effort were few. Yet on 8 May 1951 the North Korean government officially charged that the United States was engaged in biological warfare in Korea.²⁸

²⁷Quoted words from Exhibit 2 of Technical Intelligence Report TB-1336-50, 13 Nov 50, sub: Bacterial Institute of North Korea, p. 9, file 000 (Biological Warfare), Box 3132 (Medical Section, 1952), RG 338, MMFB. See also Technical Intelligence Report TB-1378-50, 1 Dec 50, sub: Cultures from Kim Il Sung Medical College, file 000 (Biological Warfare), Box 3132 (Medical Section, 1952), RG 338, MMFB.

²⁸CIA, "A Report on Foreign Press Coverage," 2 Jul 51, pp. 4, 11, 26, CIA Archives, Rosslyn, Va. General Sams' name was incorrectly reported in the Polish story.

In a note to the chairman of the United Nations Security Council, the North Korean foreign minister protested against the "heinous crime" of the United States in using smallpox as a weapon. Because smallpox was a serious problem at the time throughout Korea, due to lapsed immunizations and the movement of refugees, the choice of diseases was significant. The dissemination of smallpox germs by U.S. forces retreating from North Korea in December 1950 allegedly resulted in some thirty-five hundred cases, all among civilians. The North Korean government also demanded the trial of Generals Ridgway and MacArthur for using germ warfare. Though reported in the West, the charges apparently gained little attention, for they seemed merely another part of the war of words that accompanied the fighting, no different in kind from the accusations of gas warfare that preceded and accompanied them.²⁹

What practical success the Communist powers had in fighting disease among the North Korean population during the spring and summer of 1951 remains unclear. Immunization efforts were sporadic, despite an influx of Russian vaccines that the government administered widely among the people, and even to POWs. In May 90 percent of the North Korean Army received a formidable Russian polyvaccine. American medical officer repatriated at the end of the war reported that typhus and smallpox vaccinations were given the POWs in August 1951, using a common needle for every five men, which led to a hepatitis outbreak.

The lot of the Communist armies, however, improved noticeably in the late summer and fall. Food supplies were better for the troops on the line, providing a major boost for improved health, and despite continuing diarrhea and persistent malaria, the epidemics of the spring had ended. According to intelligence reports, typhus fell to less than 2 percent incidence, relapsing fever appeared in "only a few sporadic cases," and there was "no proven or even fairly reliable report of an incidence of cholera in North Korea." During August–December 1951, reported Capt. Ralph M. Takami, the Far East Command's medical intelligence officer, "all [enemy] troops have . . . been reimmunized against typhus fever." Like the U.N. forces across the line, the Communist powers took advantage of a static front and reduced fighting to improve the health of their armies. Midwinter found them with larger supplies of vaccines on hand, and they began a determined drive to raise the health consciousness of the public, to enforce sanitary rules, and to administer a new round of mass immunizations. This drive coincided with a major escalation of the germ warfare campaign.³⁰

²⁹Ibid., pp. 8, 12–13, CIA Archives. See also *New York Times*, 10 May 51.

³⁰First and second quotations from Rpt, Capt Ralph M. Takami, MC, Medical Intelligence Officer, Medical Section, FEC, 31 Dec 51, sub: Disease Incidence in Enemy Troops, Encl to DF, W.E.S. [William E. Shambora], Medical Section, FEC, to G-2, FEC, Attn.: Maj Lovelace, 11 Jan 52, sub: Medical Intelligence, file 350.09 (Intelligence), Box 3087 (Medical Section, FEC, Decimal File, 1952), RG 338, MMFB. Third quotation from Rpt, Takami, 12 Mar 52, sub: Biological Warfare Propaganda Broadcasts, Encl to Ltr, Maj Gen William E. Shambora, Chief Surgeon, Medical Section, FEC, to The Surgeon General, DA, 19 Mar 52, sub: Communist Propaganda Re Biological Warfare, 319.1 (Far East Command) AA, 1951–52, Box 69, Accession no. 56A–179, RG 112, (Continued)

The Opening Barrage

In February 1952 General Dean saw firsthand the scope of the new inoculation campaign. "Everybody—soldiers, civilians, adults, and children—received four separate inoculations and revaccination," he wrote. "They were monster shots, and all of North Korea had fever and sore arms." A North Korean officer told him, "We had national inoculation of the population. Nobody could move on the roads without an inoculation card. We were ready for the germ bombs when they came."³¹

In China, where the movement of armies toward Korea and the enlistment of an already inadequate medical profession in the army also had increased the danger of disease, a similar campaign began about the same time. "The present Patriotic Health Movement," declared a writer in the *Chinese Medical Journal*, "launched early in 1952, is unique in its scope and breadth and is of special importance in our battle for health. It has in fact become the driving force behind our medical work throughout the country." The people reportedly drew up "patriotic health pacts," binding themselves to observe the rules of hygiene. In Tsingtao in April a Westerner saw hundreds of schoolchildren wearing face masks and going about equipped with flyswatters and bottles. Thousands of soldiers were led out to collect insects, and for days the police directed people on similar hunts. In Harbin, mass inoculation, after considerable procrastinating by local authorities, followed the opening of the new germ warfare campaign.³²

But now the campaign had wider purposes. A concerted drumbeat began in February as Peking Radio and the *People's Daily* charged that since 28 January American aircraft had repeatedly dropped large numbers of insects carrying cholera and other disease germs. The renewed vigor of the accusation probably reflected some critical recent developments—the breakdown of the truce talks over the prisoner issue, the approaching Japanese peace treaty, and the embarrassing decision of tens of thousands of Korean and Chinese prisoners to refuse repatriation. The new campaign accompanied increasing violence among Communist POWs in the camps at Pusan and on Kojé, which may also have been a response to the impasse at Panmunjom.

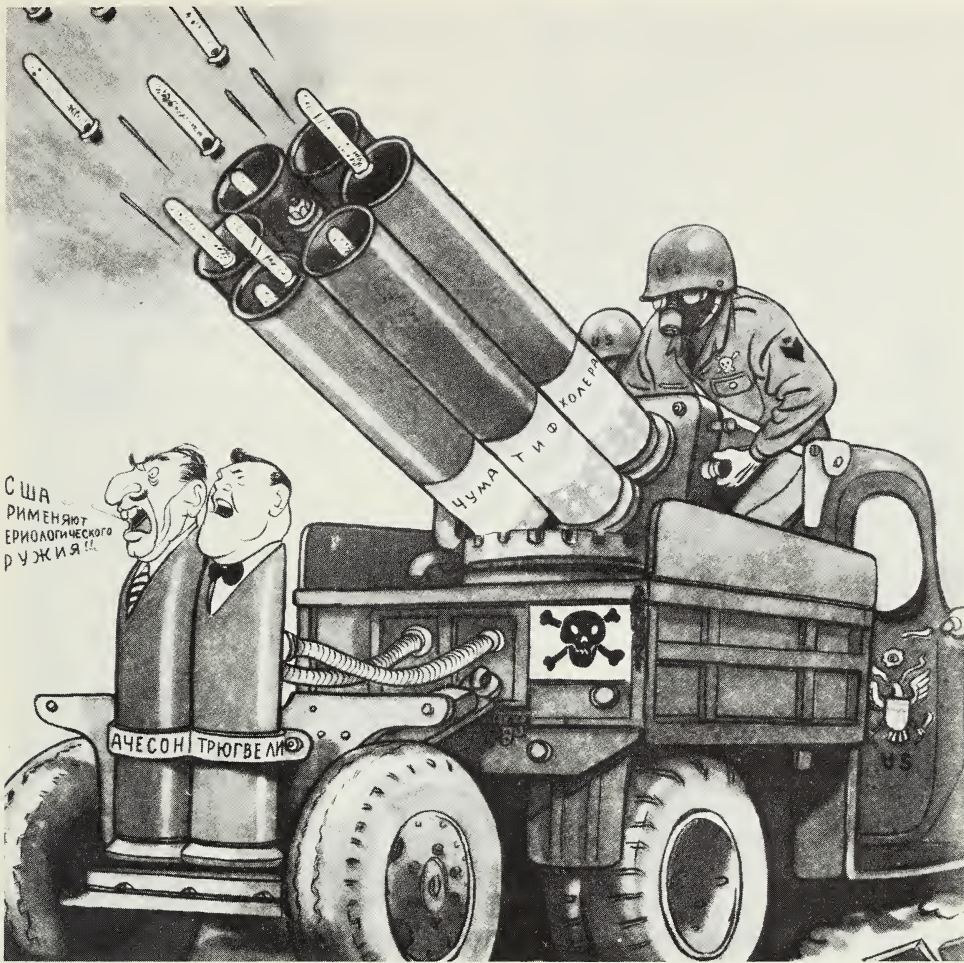
The allegations rapidly broadened. On the Imjin River front American artillery units reportedly fired containers of spiders laden with cholera and typhus germs. By the first weeks of March the Communists expanded their charges to include germ raids on China itself. According to Chinese reports, infected animals were dropped at Antung; at the mouth of the Yalu River, where the People's Republic maintained a large base for Russian-built MIG fighters; at other sites near the river; and in Liaotung Province. In a formal statement

(Continued)

WNRC. See also Deane, *I Was a Captive in Korea*, pp. 170–71; Dean, *General Dean's Story*, p. 264; Rpt, Maj Lee B. Grant, sub: Operation BIG SWITCH: Medical Intelligence Processing, pp. 11–13, file 383.6 (Operation "Big Switch") 1953, HRB.

³¹Dean, *General Dean's Story*, pp. 276–77.

³²First quotation from Shih-Shan Fang, "Effect of War on the Health of the People," *Chinese Medical Journal* 71 (September–October 1953): 326–27. Second quotation from Office of Current Intelligence, CIA, Current Intelligence Digest, 7 Apr 52, CIA Archives, Rosslyn, Va. See also Information Report no. 00–B–55704, 4 Sep 52, CIA Archives.



COMMUNIST CHARGE OF GERM WARFARE. *This cartoon, which appeared in the Russian magazine Krokodil in 1952, portrays an American soldier firing off test tubes of germs while Secretary of State Dean Acheson (left) and U.N. Secretary Trygve Lie (right) mouth propaganda.*

Foreign Minister Chou En-lai charged the United States with conducting germ warfare in Manchuria and demanded the punishment of American fliers.

Meanwhile, the germ warfare charge served the Communist powers well at home by stimulating the public health campaign aimed at preventing any recurrence of the conditions of 1951. Monitored Chinese broadcasts reported that Premier Kim Il Sung had issued a decree placing his country in a virtual state of emergency to combat bubonic plague. The National Extraordinary Anti-Epidemic Committee, the Ministry of Public Health, and the army's Medical Bureau were ordered to mobilize all forces to wipe out germ-carrying insects. "The bacteriological warfare propaganda," according to imprisoned American medical officers following their release at war's end, "was directed primarily toward the civilian population. The town governments enforced clean-up programs,

mass immunizations, boiling of clothes and in some cases dusting individuals presumably with a lousicide.”³³

In North Korea a spring antiepidemic campaign got under way with an April radio broadcast by Hwang Jung Hyop, vice chief of the Sanitation and Antiepidemic Bureau of the Ministry of Public Health. “The American imperialist murderers,” he declared, “have recently been engaging openly in the villainous germ warfare.” Aircraft were dropping flies to spread cholera, typhoid, and paratyphoid; fleas to carry plague germs; and a melange of rats, bedbugs, spiders, grasshoppers, ants, and crickets to disseminate “eruptive typhus,” Japanese encephalitis, malaria, and “other epidemic diseases of the tropical zone.” The “American cannibals” were attempting not only to murder people en masse at the front and in the rear area but also to annihilate cattle, fowl, and crops. The response to this apocalyptic threat was prosaic and rational: clean up privies, exterminate rats, wash bodies and clothing frequently, avoid eating raw food, kill flies, wash hands before eating, and boil water before using. Melodrama played its part in North Korea; so did minute organization. Six “big clean-up days” were ordered for every month, on the second, seventh, twelfth, seventeenth, twenty-second, and twenty-seventh. Antiepidemic committees formed a new and comprehensive hierarchy, from the lowest to the highest administrative divisions of the country. The committees carried out daily inspections and reported all cases of disease, a precaution fundamental to epidemic control here justified as vigilance against an atrocious enemy. The Red Cross Association, the Democratic Youth League, and the Democratic Women’s League pitched in. Propaganda media were utilized “to fullest capacity.” In North as in South Korea, a still largely medieval nation headed perforce toward modern sanitation under the stress of war.³⁴

American prisoners received similar treatment. The first inoculations of 1952 were administered about a month after intensive germ warfare indoctrination lectures began. Many POWs were told the shots would protect them from diseases that American planes were spreading. Inoculations were systematic, “given by the roster,” and an attempt was made to include everyone. During the year shots were given for typhus, cholera, plague (twice), plus a combined serum supposed to protect against cholera, typhoid, and paratyphoid. The Chinese evidently believed their own propaganda, searching for insects and forbidding prisoners to swim in water that had supposedly been contaminated from the air.³⁵

Charge and Countercharge

The immediate American reaction to the germ warfare charge was less than candid. In comparison to 1951, most evidence for 1952 pointed to improving

³³Quoted words from Rpt, Grant, sub: Operation BIG SWITCH, p. 21, HRB. See also *New York Times*, 2, 4–5, 7–8 Mar 52.

³⁴Broadcast from Pyongyang, 15 Apr 52, in CIA Daily Report, Foreign Radio Broadcasts, no. 78–1952, 18 Apr 52 (Foreign Broadcast Information Service), p. 2, CIA Archives, Rosslyn, Va.

³⁵Rpt, Grant, sub: Operation BIG SWITCH, p. 23, HRB.

health conditions in North Korea. Yet American officials took the facile line that the intent of the Communist charge was to cover up the existence of real epidemics. Both Secretary of State Dean Acheson and General MacArthur were unwise enough to cite plague as one of the supposed epidemic diseases. This provided a mirror image to the Communist story that the United States was attempting to spread plague, and it further obscured the fact that the Black Death, though dreaded by both sides, apparently had never broken out at all.

However, the Western counter-charge that real epidemics were occurring was plausible, because of the events of 1951 and the medieval disease environment that prevailed in most of China and North Korea. American officials deplored the failure of Communist governments to care for their people, ignoring the factors of poverty and overcrowding, of war and social upheaval, and of scientific backwardness and entrenched tradition against which those governments struggled with little to aid them but Russian vaccines, social regimentation, and the psychology of wartime. Dialectically, the Communists were caught in a trap, obliged to claim that they were victims of germ warfare yet to deny the existence of real epidemics and to refuse the offers of assistance that soon rolled in from the World Health Organization and the International Red Cross.³⁶

The Far East Command's military intelligence officers, however, found themselves trying to dampen reports of enemy epidemics that they knew to be false. Captain Takami warned that "epidemics of plague have never been reported from Korea." Reports of cholera epidemics in North Korea had "never been confirmed," though he admitted the possibility of outbreaks among civilians. Maj. Gen. William E. Shambora, the chief surgeon, warned the surgeon general of the problems Shambora's office might face if obliged to contradict a public statement by General MacArthur that plague existed in North Korea.

Repeated interrogations of PsW [POWs] and refugees from North Korea together with interviews of agents operating in enemy territory have failed to offer any evidence of the presence of either plague or cholera in North Korea. However a press statement recently given out inadvertently by the United Nations Commander to the effect that he had evidence that plague was present in North Korea has made the publication of the above statement somewhat difficult. . . . In view of the statement by the United Nations



MAJ. GEN. WILLIAM E. SHAMBORA

³⁶Office of Current Intelligence, CIA, Current Intelligence Digest, 24 Mar 52, CIA Archives, Rosslyn, Va.; *New York Times*, 9 Mar 52.

Commander . . . it is suggested that any statements from your office to the contrary indicate that they are based on evidence available to you and *not be credited to me or my office*.³⁷

Chinese fabrications followed American misstatements. Evading investigation by the International Red Cross and the World Health Organization, China instead called upon a variety of friendly witnesses. The most impressive group was the International Scientific Commission for the Investigation of the Facts Concerning Bacterial Warfare in Korea and China, made up of sympathetic Westerners plus the chief Soviet medical expert from the Khabarovsk trials. The commission viewed pathological studies of Koreans who had died of anthrax and reported finding the organism of plague in human fleas. Testimony by North Koreans and others connected the appearance of disease with overflights by American warplanes. Intermediate between the two was an amazing variety of supposed vectors—including spiders; nonbiting flies; other insects that have no known role in spreading any illness; and small wild rodents, such as voles. In some cases the commission itself queried the evidence, usually on the grounds that the technique of germ warfare was not fully understood. At no time did the commission consider the possibility that the evidence had been cut from the whole cloth. A formidable illustrated volume of testimony, analysis, and conclusions resulted from the commission's work, which, published in Peking in August 1952, became the chief theoretical support of the germ warfare campaign.³⁸

If the 1951 campaign seemed disjointed, the 1952 campaign—like the May uprising on Kojé—had the look of a concerted effort to win a major propaganda advantage. Taking up the cudgel, the Soviet Union carried the accusation before the United Nations Disarmament Commission, causing, if possible, an even deeper freeze in relations with the United States than already existed. The spectacular and intriguing nature of the charge won the Soviets a wide hearing in the world press, both Communist and non-Communist. However, the effect upon world opinion remained problematic. Studies of press and radio reaction by the Central Intelligence Agency indicated that many in non-Communist bloc nations were skeptical. In Western Europe some distinguished intellectuals accepted the Chinese evidence with little difficulty. Then and later, critics found some of the evidence irresistibly comic: “The dissemination systems and the vectors,” one recently concluded, “if not the agents, were almost all quite bizarre.”³⁹

One aspect of the campaign was not amusing, however. Downed American pilots were put under severe pressure—most commonly by sleeplessness, isolation, and threats of death—to confess to waging germ warfare. Airmen who yielded were sometimes paraded from camp to camp to lecture other Americans

³⁷Ltr, Shambora to The Surgeon General, 19 Mar 52, RG 112, WNRC.

³⁸*Report of the International Scientific Commission for the Investigation of the Facts Concerning Bacterial Warfare in Korea and China* (Peking: Foreign Languages Publishing House, 1952). The validity of the charges is assessed in John Cookson and Judith Nottingham, *A Survey of Chemical and Biological Warfare* (New York: Monthly Review Press, 1969), pp. 57–63 and 297–308; in Stockholm International Peace Research Institute, *The Problem of Chemical and Biological Warfare: The Prevention of CBW*, 5 vols. (New York: Humanities Press, 1971–75), 5:238–58; and in Cowdrey, “‘Germ Warfare’ and Public Health in the Korean Conflict.”

³⁹Cookson and Nottingham, *A Survey of Chemical and Biological Warfare*, p. 307.

on the alleged crimes of their government. Once they had returned to the United States, all revoked their confessions on the grounds that they had been obtained under duress. The language used in some supposedly spontaneous statements—"Let us change the tune of the piper and dance to the tune of peace," said one, while another exclaimed, "Speak! Act! and your efforts for peace will be blessed"—was often unconvincing. But some fliers produced highly circumstantial accounts that would be admissible as evidence, except that they were embedded in the fabrications of the germ warfare campaign.⁴⁰

The campaign served many functions, chiefly in the fields of diplomacy and propaganda. General Dean's rather loose captivity during 1952 enabled him to observe some of its practical military effects in North Korea. "The civil population," he noted, "became so inflamed [by the germ warfare stories] that a downed airman had virtually no chance of getting away from his wrecked plane or parachute. Although Chinese and Korean intelligence officers always raced each other for downed airmen, most of the captives were made by farmers or villagers long before the military arrived."⁴¹

The type of warfare that developed in Korea after the stabilization of the front was not without historical parallels. During World War I armies on the Western Front dug in, besieging each other for years in a war that seemed unwinnable. At the same time, in their military frustration the combatants fought a war of words to win support from noncommitted nations—most important, to influence the policy of the United States. While precise analogies are impossible in view of the intense ideological passions of the Cold War, such developments did share a common character with much that happened in Korea. With the armies in deadlock the contenders sought to win the sympathy of mankind—or, if not, to win the condemnation of their enemies in the court of world opinion. In this atmosphere the germ warfare campaign emerged as the finest flower of ideological war. Beginning in local medical conditions, it spread to affect, and in some respects to poison, the world of ideas. For a short time the campaign was a touchstone by which believers in the two world systems could demonstrate their loyalty and affirm their support to the side they had chosen, or had felt compelled to choose. In the medical history of the Korean War the episode remains an embarrassment for the chronicler, hard to assimilate, impossible to exclude. And the question of who won the controversy is as difficult to answer as the question of who won the Korean War as a whole.

⁴⁰Quoted words from *ibid.*, p. 306. Compare Office of Current Intelligence, CIA, Current Intelligence Digest, 14 Jul 52, OCI no. 6439, p. 10, and information from Foreign Documents or Radio Broadcasts, "Non-Communist Radio Comment on BW Charges," 7 Feb–7 Apr 52, Report no. 00–F–229. Both in CIA Archives, Rosslyn, Va. Also of use is the *New York Times*, 2–3 Apr 52, 4 May 53, and 7 Sep 53. On pilots' confessions, see transcript of Interv, Wilfred G. Burchett, *Ce Soir* correspondent, with 1st Lt John Silas Quinn, 30 May 52, as detailed in DA Msg B 312317, 010515Z Jun 52, file 470.6–2 (Korea) F, 1951–52, Box 50 (Geographic Files, 1951–53, 386.3 (Korea) F to 721–End (Korea) F), Accession no. 56A–198, RG 112, WNRC. See also *Depositions of Nineteen Captured U.S. Airmen on Their Participation in Germ Warfare in Korea*, 1 Dec 53, and *Statements by Two American Air Force Officers*, 16 May 53, both in Library of Congress, Washington, D.C.; and George Winokur, "The Germ Warfare Statements: A Synthesis of a Method for the Extortion of False Confessions," *Journal of Nervous and Mental Diseases* 122 (July 1955): 65–72.

⁴¹Dean, *General Dean's Story*, p. 278.

CHAPTER 8

Medical Support Behind a Stable Front

Prime gainers from the new kind of warfare were the Korean rear areas. The stabilization of the front permitted rapid maturing of the medical support system. Command of the air allowed convoys to roll undisturbed, laden with all kinds of supplies. While the Chinese and North Koreans had to burrow underground, United Nations (U.N.) hospitals and depots could build in the open, free from attack. Under the Far East Air Forces' umbrella the medical system developed in near ideal conditions. Despite the ruin of war, the poverty and misery of many Koreans, and the sporadic fighting between South Korean troops and guerillas, the rear areas slowly began to assume a more normal aspect.

Here, as at the front, rotation presented many difficulties for military commanders and administrators. Together with the doctor draft and the general draft it meant near 100-percent turnover in many medical units during 1951, and continuing turbulence thereafter. The problems involved in continuous retraining meant that military medicine, from its simplest to its most professional aspects, became an art that medics had not only to learn but also relearn as they worked with soldiers who themselves continuously came and went through the doorway marked "Big R." Rotation was one of the ways that America coped with the Korean conflict once it became apparent that the war would not be a short one, and in this sense it, too, represented a maturing of the system that supported the battle.¹

Organization of the Rear Areas

Within the Eighth United States Army, Korea (EUSAK), the 2d Logistical Command organized and controlled the rear areas. It provided direct support to the Eighth Army, requisitioning supplies from the Japan Logistical Command (JLCOM) and overseeing storage and distribution. Its police duties included security in metropolitan Pusan, in Seoul-Inchon, and in other important military areas. The increasing burden of housekeeping chores led the Eighth Army

¹Civilian health and welfare is discussed in Chapter 10 of this volume.

surgeon to suggest making the command a JLCOM advance section. Instead, the Far East Command on 10 July 1952 established at Taegu a more weighty and complex structure—the Korean Communications Zone (KCOMZ).²

Under the new headquarters was a mixture of area commands and organizations having special functions. The major subordinate commands were the Korea Base Section, the United Nations Civil Assistance Command, Korea (UNCACK), and the Prisoner of War Command. Over the course of the year that followed, the 3d Transportation Military Railway Service and the Taegu Military Post were added, the first to control the increasingly heavy rail traffic that supported the front and the second to provide services and security in and around the KCOMZ headquarters. UNCACK, on the other hand, was abolished on 1 July 1953 and replaced by the Korean Civil Assistance Command (KCAC), directly under the United Nations Command in Tokyo.

The KCOMZ headquarters reported to the Far East Command (FEC). Its primary functions were and remained advisory, with operations in the hands of the many specialized subordinate commands. Of these, the Korea Base Section was simply the old 2d Logistical Command under a new title, but with broader powers. Its subordinate elements were the 6th Army Medical Depot, the Swedish Red Cross Hospital, and three evacuation hospitals, which were reorganized as station hospitals in 1953. The field hospitals serving the vast prisoner population fell under the Prisoner of War Command, the medical trains under the 3d Transportation Military Railway Service. Beyond this, the KCOMZ on 1 August 1951 assumed control of all major medical installations in Korea, except the MASHs and the 11th and 121st Evacuation Hospitals. Within its geographical area—mostly south of the 37th Parallel and about seven times the size of the region under EUSAK—it controlled all medical service units except those few installations, designated Class II, that remained under the Eighth Army. The KCOMZ furnished medical logistical support to the fighting forces; handled rail evacuation; provided medical, dental and veterinary care to all U.N. troops in its area, plus the prisoners of war (POWs); and, through UNCACK, directed U.N. medical services on behalf of the civilian population as well.³

A New Army

Trying to staff the Army hospitals and to fill the medical units was a frustrating endeavor. The draft gave and rotation took away. The doctor draft, killed in 1948 by the American Medical Association's opposition, was revived with over-

²EUSAK, Annual Report of Medical Service Activities, 1951, pp. 15, 78, file 319.1-2 (EUSAK) Far East-1951, HRB; 8086th Army Unit, Military History Detachment, "Organization of the Korean Communications Zone," vol. 1, pp. 1 and 4, Ms no. 8-5.1A DJ, RG 319, MMFB; Korean Communications Zone (hereinafter cited as KCOMZ) and FEC and USAFFE, Annual Reports of Medical Service Activities, 1952, pp. 1-2 and p. 72, respectively, files 319.1-2 (KCOMZ) and (FEC and USAFFE) Far East-1952, HRB.

³8086th Army Unit, "Organization of the Korean Communications Zone," vol. 1, pp. 1-2, and vol. 2, encl. 10, RG 319, MMHB; EUSAK, Annual Report of Medical Service Activities, 1952, pp. 3, 6 and annex IV, p. 3, file 319.1-2 (EUSAK) Far East-1952, HRB; 8086th Army Unit, Military History Detachment, "Transportation of Supplies," p. 24, Ms no. 8-5.1A AA.B, RG 319, MMHB;

(Continued)

whelming congressional support after the opening of the Korean War. Both the medical association and the reserve medical officers now backed it, motivated in part by a desire to satisfy the needs of the armed forces by placing in the first priority for the draft six thousand Army and Navy Specialized Training Program graduates (ASTPs and V-12s) who had not yet served. For their part the armed services turned to the draft for the usual reason: Efforts to persuade physicians to volunteer had no more success after the war began than before. As passed by the lawmakers in early September 1950, the draft legislation provided for induction first of ASTPs and V-12s with less than ninety days of service; second, those with ninety days but less than twenty-one months of service; third, other doctors, dentists, and veterinarians with no military service since 1940. When these categories were exhausted, professional men with recent military service were to be taken in inverse ratio to the length of their service.⁴

However, the inevitable delays in making the legislation work meant that no drafted medical officers reached Korea until January 1951. Meanwhile, amid complaints from men whose lives were being disrupted and reminders from the unsympathetic that reserve service was voluntary, the medical reservists—most of them veterans of World War II—continued to be called. Few men who were liable to the draft volunteered for reserve commissions, despite the Army's initial hopes. During 1951 regular draft calls summoned medical professionals into the service. By the end of August the standard five-week course at the Medical Field Service School at Fort Sam Houston, Texas, had given some twenty-five hundred medical, dental and Medical Service Corps officers their initial introduction to the Army and its ways. From that time forward the draft became increasingly important, and during 1952 over 90 percent of the medical officers required by the Army Medical Service in the Far East Command were procured through the doctor draft.⁵

In tandem with the general draft, the doctor draft brought a different kind of medical service into being in the Far East Command. The key to the rapidity of the change from an overwhelmingly volunteer to a largely conscript service was the rotation system. During 1950 the Medical Service had begun to rotate medical and dental officers to Japan for professional refreshment, as well as nurses on grounds of their supposed inability to sustain the stress of front-line service. In March 1951 the Far East Command announced a general rotation

(Continued)

USAFME and EUSAR, "Logistics in the Korean Operations," vol. 1, p. 28, Ms no. 8-5.1A AZ, RG 319, MMHB. A useful account of the Korean Communications Zone is Gary Jennings, "The KCOMZ Story," *Army Information Digest* 8 (October 1953): 56-60.

⁴U.S. Congress, House, *Congressional Record*, 81st Cong., 2d sess., 30 Aug 50, vol. 96, pt. 10, pp. 13855-870; Public Law no. 81-779, 9 Sep 50; Ltr, President Harry Truman to Secretary of Defense, 9 Sep 50, in SG Conference Notes, 12 Sep 50; extract from Ltr, Col C. G. Blakeney, Chief of Legislative Liaison, to Honorable Harold D. Donohue, House of Representatives, [circa August 1950], HSF (Blakeney-1950), HRB; Weekend Letter no. 9, Maj Gen R. W. Bliss, Surgeon General, DA, to Maj Gen Edgar E. Hume, Chief Surgeon, FEC, 5 Sep 50, file 200 (Personnel Letters Between SGO and Medical Section, FEC), Box 3099 (Medical Section, FEC, General Records, 1950), RG 338, MMFB. Most of this group of ASTPs and V-12s had escaped service because the program terminated while their education was incomplete.

⁵"Washington News," *Journal of the American Medical Association* 144 (October 1950): 470; Historical Unit, U.S. Army Medical Service, History, Medical Service Activities, 1 Jul 50-30 Aug

policy covering all who served in Korea. The basic principle was to return such men and women to the zone of interior, beginning with those who had the longest combat exposure. None, however, could leave the war zone until a qualified replacement had arrived to take his place. After some initial confusion the commander-in-chief came up with a plan dividing the command into three zones. Those who served with combat units in Korea received constructive credit of four months for each month served; those with noncombat units, two; those outside Korea, one. Troops were eligible for rotation after earning thirty-six months of credit, which translated into nine months of actual service for those in forward areas.⁶

Clearly, such a system implied heavy demands for replacements, and when they initially failed to arrive on time much bitterness resulted among people on the line. By the end of September, however, an influx of replacements, most drafted, permitted rotation of almost all the eligible medical and dental officers. A mass arrival of Medical Service Corps and warrant officers during that month, producing a temporary surplus on the rolls, did not completely relieve the backlog of officers eligible for rotation, but by the end of October most had departed. The same period also saw the departure of other groups: residents who had come to the Far East on five months of temporary duty (TDY) just before the war broke out; Navy doctors, who returned to their own service; and other military and civilian residents, who went home to resume their interrupted studies.

Adding normal losses for death and injury, illness or compassionate causes, a near revolution in staffing took place. Among those who departed was Colonel Dovell, the Eighth Army surgeon. In a month and a half—mid-August to 1 October—the chief of every division in the Eighth Army's Medical Section rotated, obliging Dovell's replacement, Col. Thomas N. Page, to build up an entirely new staff. During 1951 the Far East Command saw the departure of its chief surgeon, General Hume; of its consultant in preventive medicine, Col. Arthur P. Long; of its psychiatric consultant, Colonel Glass; of its medical consultant, Col. Francis W. Pruitt; and of many others, both of high rank and low.⁷

In the next year upheaval became institutionalized. In theory rotation should have distributed the burden of service in Korea, built up a pool of trained personnel, and avoided turbulence by integrating into units newcomers who could learn from veterans and then teach others in their turn. But in practice the ideal of regularly replacing a certain percent of the command each month was unattainable. Ruled by the tactical situation, the coincidence of rotation dates, and the availability of replacements, the system moved by jerks and starts. Because every failure to meet the announced criteria brought bitter complaints

51, pp. 45–46, file 314.7–2 (Army Medical Service Activities, 1 Jul 50–30 Aug 51), HRB; FEC and USAFFE, Annual Report of Medical Service Activities, 1952, p. 13, HRB.

⁶FEC, Annual Report of Medical Service Activities, 1951, pp. 136–37, file 319.1–2 (FEC) Far East–1951, HRB.

⁷EUSAK and FEC, Annual Reports of Medical Service Activities, 1951, pp. 81–82 and pp. 25–26, 132–37, respectively, files 319.1–2 (EUSAK) and (FEC) Far East–1951; FEC, Report of ETMD, October 1951, p. 22, file 350.05 (FEC) 1951. All in HRB.



A CONTINGENT OF MEDICAL OFFICERS. *Left to right, front row: General Shambora; Surgeon General Armstrong; Brig. Gen. Yun Tchi Waang, surgeon general of the South Korean Army; Col. L. Holmes Ginn, Jr.; Brig. Gen. Earle Standlee, surgeon general of the Air Force; and Col. Thomas N. Page.*

from men who had their thirty-six constructive months in hand, the Far East Command struggled to maintain morale, avoid congressional queries, and fend off adverse press reaction by meeting rotation dates even when replacements were not available. The result was that the command was soon understrength in every corps of the Medical Service, except the Dental. Late in 1952 the criterion for rotation was raised to thirty-eight months, but for the forward zone.⁸

During 1951 the massive turnover had ended in generally satisfactory staffing levels, for new people were available to replace the old. During 1952, however, nagging problems emerged as the draft and rotation interacted. Command experience was at a premium as veterans departed, yet—ironically—an oversupply of some medical specialists developed. Nurses were too few, Medical Service Corps officers were abundant but short on experience, and trained enlisted people were difficult to come by.

Washington tended to justify shortfalls by the drop-off in military activity along the front. In 1952 the Office of the Surgeon General requested that the Far

⁸FEC and USAFFE, Annual Report of Medical Service Activities, 1952, p. 12, HRB.

East Command accept “a small calculated risk” in regard to the supply of physicians. Doctors were said to be too few in civilian life, casualties in the command were at a low level, and the surgeon general feared “criticism from civilian medicine that [the] Armed Forces are wasteful in utilization of physicians”—a familiar theme. In the event that full-scale hostilities were renewed, the “staffing level could be restored by airlift of medical officers.” In reply the Far East Command declined to agree to any decrease, pointing out that it was already taking a risk by operating with about 85 percent of its authorized strength under the tables of organization and equipment (T/O&Es) and tables of distribution. Combat divisions were functioning with thirty-two doctors each instead of forty-two, evacuation hospitals with twenty-four instead of twenty-nine, and MASHs with twelve instead of fourteen. In Japan itself the number of physicians at each of the four general hospitals was reduced from twenty-eight to eighteen, and “a proportionate decrease was effected in most of the other hospitals.” In consequence, the rotation of doctors for the time being had almost come to a halt.⁹

By this time the stabilization of the front and the opening of negotiations had drastically changed the image of the war, from a crisis in the international conflict between the Communist and non-Communist powers to a purposeless struggle in which victory was no longer possible, or at any rate no longer pursued. Most Americans who could avoid the war did so; those who served submitted only as long as they must to a grim necessity. The declining activity in Korea reminded the Army of its obligations elsewhere in the world. A sign of the general tendency to minimize the importance of Korea as far as possible was the curtailment of battlefield promotions in August 1952. Time in grade began to count for more than it had during the period of heavy combat. First lieutenants in the Medical Corps and Dental Corps were promoted to captain upon completion of twenty months of active duty; 2d lieutenants in the Medical Service Corps and Army Nurse Corps to 1st lieutenant after eighteen months. Promotions for enlisted men in medical units were cut back sharply, with the result that men of E-4 rank and below often filled slots tagged for E-5s to E-7s.¹⁰

At the top of the medical tree, command jobs existed with no one to fill them. At the end of 1952 the Eighth Army had 6 of its 11 authorized Medical Corps colonels, 14 of 37 lieutenant colonels, and 15 of 90 majors. It possessed in all 36 field-grade officers against a T/O&E requirement of 139. Only three of its eight hospital commanders and only two of its six divisional medical battalion commanders had had previous commands. Half the division surgeons lacked staff experience. During the first six months of 1952 a shortage of well-trained board-qualified general surgeons developed, and by the latter part of the year the Far East Command was obliged to assign specialists to such slots instead of the major hospitals. Spot shortages also occurred in those specialties—anesthesiology, orthopedics, urology, otolaryngology, neurosurgery—that had experienced problems intermittently since the war began. By and large,

⁹Ibid., pp. 13–14, HRB. Quotation on p. 14.

¹⁰Extract from Ltr, Brig Gen William E. Shambora, Chief Surgeon, FEC, to Maj Gen George E. Armstrong, Surgeon General, DA, 12 Feb 52, HSF (Shambora–1952), HRB.

however, professional expertise was common, command rank and experience rare. Professionalization, the draft, and rotation were recreating in Korea the very situation that had typified many World War II theaters.¹¹

Serious shortages developed as well among enlisted men and nurses. Theater personnel offices filled first the requirements of the line units, restricting the supply of aidmen and technicians, especially of those with prior training. Because women still could not be drafted, Army nurses went to Korea on a voluntary basis, and the continuing shortage could not be met by denying rotation to those who had served. A severe shortage of nurse anesthetists appeared in 1951 and, despite training in the hospitals, apparently continued during 1952. A gradual erosion of strength in the Army Nurse Corps—about 7 percent from mid-1951 to the end of 1952—worsened the special problems of the Far East Command, and had to be met by a variety of expedients.

Army nurses were relieved of much of the routine work in hospitals, both in patient care and administration, and enlisted personnel trained as practical nurses. In 1951 the Office of the Surgeon General discussed again the question of opening the Army Nurse Corps to male nurses, only to run into the baffling tangle of legislation and sentiment that declared nursing to be women's work. U.N. nurses helped to take up the slack; during the same year, 122 women—Danish, Swedish, Thai, Norwegian, Italian, Turkish, French, Dutch, Belgian and Greek—served in the Far East Command. Japanese nurses, graduates of Class A schools, worked in the hospitals in their homeland; Korean nurses from similar Korean schools in the prisoner-of-war hospitals. The stable tactical situation of 1952, the continued rapid evacuation, and the assignment of Army nurses to the hospitals with the heaviest work loads (rather than strictly by T/O&E) enabled the system to function, though shortages continued in both the KCOMZ and the Japan Logistical Command.¹²

Training

High turnover implied training many newcomers. Skilled medical enlisted men remained the major problem. "Rotation was the big news in the Far East Command about 1 March [1951]," said a report, "and the 'Rotation Blues' was about to be adopted as a theme song by the Medical Section, GHQ, FEC, since it was found that adequately trained personnel were not available. . . ." With a backlog of almost five thousand eligibles waiting impatiently to go home it was "fairly obvious" that a training program would have to be instituted.¹³

¹¹EUSAK and FEC and USAFFE, Annual Reports of Medical Service Activities, 1952, pp. 1–2, annex II, pp. 3–4 and p. 47, respectively, HRB.

¹²FEC, Annual Report of Medical Service Activities, 1951, p. 89; FEC and USAFFE, Annual Report of Medical Service Activities, 1952, pp. 57–60; FEC, Report of ETMD, February 1952, file 350.05 (FEC) 1952. All in HRB. See also Nursing Division, OSG, Summary of Major Activities, 9 Sep 51–31 Dec 52, pp. 1–2, file 314.7–2 (Army Medical Service Activities, 9 Sep 51–31 Dec 52), HRB. The proportion of ANCs to total nurses in the Far East Command declined slightly during 1952, but remained in the range of 83–88 percent.

¹³FEC, Annual Report of Medical Service Activities, 1951, p. 117, HRB.

At the behest of the FEC chief surgeon, that summer the Japan Logistical Command established the Far East Medical Service Specialist School at Camp Shinodayama, near Osaka. Early courses included four- to twelve-week sections for X-ray, pharmacy, laboratory, and operating room technicians and for field medical aidmen. Students sent by the command returned to their units after training; men taken from the pipeline were assigned throughout the command, with first priority to the Eighth Army, which apparently received 80–90 percent of the graduates. After a brief exchange with the adjutant general, the 250 spaces allotted to the school by the Japan Replacement Depot were filled automatically. Some question remained as to whether the Japan Logistical Command was selecting the students at random. Studies showed that only 4.5 percent had received medical basic, which corroborated the Medical Service's suspicion that the command was sending infantry-, armor-, and artillery-trained men (who made up 90 percent of the allotment) to become medics and medically trained men to line units.¹⁴

Various problems continued to be apparent, some as old as the Medical Service, some as new as the rotation system. The Medical Replacement Training Center at Fort Sam Houston, Texas, found that training divisions were sending their worst men to be medics, just as line units had done since the American Revolution. A second center was set up at Fort George G. Meade in March 1951, drawing its 220 men per month direct from the induction centers. A higher caliber of personnel was noted at once. During 1951 the highly specialized military occupational specialty (MOS) 1229—Medical Equipment Maintenance Technician—remained critical. Inferior applicants in the zone of interior led to an excessive failure rate at the St. Louis Medical Depot, where 1229s were trained; in Japan brief instruction left many incompetent at the job for which they were supposedly qualified. Meanwhile, medical equipment became ever more complex, often with intricate electronic components. Complaints to the Office of the Surgeon General and much retraining resulted, but these measures apparently did not solve the problem.

During 1952 the oddities of the rotation system also resulted in severe problems with the supply of field medical aidmen. In May, after the Camp Shinodayama school was abolished, aidmen trained at the Eta Jima Specialist School. Serving at the front in Korea, they earned the maximum constructive service time and consequently rotated in a fashion likely to cause vertigo in a personnel officer. Too few trained men were coming from the zone of interior, but the quota set for the pipeline by the school was not met—could not be met, according to the Far East Command's G-1 (personnel) section, because men with combat MOSs could not be diverted and those with noncombat MOSs were too few. As a final note, the dangerous nature of the job meant high losses by death, injury, and capture, further reducing the number of men on whom, when all was said and done, the whole medical superstructure rested. At the end

¹⁴*Ibid.*, pp. 117–19, HRB; Ltr, General Headquarters, FEC, AG 352 GC-TNG, 10 May 51, sub: Training of Medical Specialists, referenced in Japan Logistical Command (hereinafter cited as JLCOM), Report of ETMD, May 1951, p. 22; JLCOM, Reports of ETMD, July 1951, p. 3, and September 1951, p. 53. ETMDs in file 350.05 (ETMD, Far East, JLCOM, 1951), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112, MMFB.



MEDICAL EQUIPMENT MAINTENANCE TECHNICIANS AT WORK

of 1952 the command lacked twenty-four hundred of the more than eight thousand authorized aidmen. Though the shortage was nearing 30 percent, no solution had appeared.¹⁵

The Far East Command's decision to terminate the Shinodayama school apparently was based upon assurances that greater numbers of qualified replacements would be received through the pipeline. The Japan Logistical Command was suspicious from the first and recommended that the school be retained. When it was abolished, the logistical command set up its own courses for physical therapy technicians at the Kyoto Army Hospital and for medical equipment mechanics at the Japan Medical Depot. In Korea a chorus of complaints indicated that new technicians received from the zone of interior were not living up to their billing. According to the Eighth Army surgeon, the

caliber of laboratory technicians now being sent to this organization is far below minimum standards. The graduates of the Laboratory Technicians School at Fort Sam Houston are universally unprepared to perform any of the routine procedures employed in the

¹⁵FEC, Annual Report of Medical Service Activities, 1951, pp. 139-40, HRB; JLCOM, Report of ETMD, May 1952, pp. 3-4, file 350.05 (ETMD, Far East, JLCOM, 1952), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB; FEC and USAFFE, Annual Report of Medical Service Activities, 1952, pp. 19 and 31, HRB; extract from TSG Notes no. 7, February 1954, pp. 5-6, HSF (TSG Notes-1954), HRB.

laboratory. . . . They are not particularly interested in laboratory work, but rather seem to regard their MOS as insurance against more rigorous and dangerous assignments.

Pointing out that the quality of medicine in any hospital depends in great measure on the quality of the laboratory work, the report concluded that the hospitals must rely upon the few technicians who were both willing and able and upon the universal Army cure for defective preparation, on-the-job training.¹⁶

Clinical training for doctors moved in familiar grooves, though greater maturity in the professionalization program was evident by comparison with the first year of the war. On arrival in Japan newly assigned physicians attended orientation courses at the JLCOM hospitals, set up to give them some familiarity with Army ways. Dating from the earliest days of the war, the program apparently underwent little change except for location. By 1951 instruction was carried out at installations in the Tokyo area to minimize transport and similar problems. For newcomer and veteran alike, conferences and symposia increased in number and sophistication. Radiologists, ophthalmologists, internists, and other specialists met at both regional and general conferences; dispensary physicians attended meetings on general medicine.

In the Eighth Army—and in the KCOMZ after its establishment— postgraduate courses were designed to utilize the talents of visiting consultants who, while remaining inspectors, became instructors as well. Such “courses” might last only a few days, for the students were busy people and the consultants’ visits to any given area usually short. Most were concerned with imparting the newest wrinkles in one or another specialty to professionals who already knew the basics, which they practiced every day. Refresher training was also provided for battalion surgeons and for the Medical Service Corps officers serving as assistant battalion surgeons. In Korea the field and evacuation hospitals were usually the sites chosen. After the 8228th MASH had become a hemorrhagic fever center, however, lectures there informed both newcomers and veterans about Korea’s surprise contribution to American medical literature. A civilian consultant from Harvard spoke in Pusan on diseases of the chest; at some meetings, papers were presented, and physicians were encouraged to bring up interesting cases for discussion. Largely the work of General Ginn, who had succeeded Page as Eighth Army surgeon, the development of these brief courses indicated that medical men in Korea now had time to study as well as to work on patients.¹⁷

Both the rotation system and the ever-changing nature of modern medicine helped to make continuous professional training a feature of the Korean scene. The end of the war of movement enabled personnel from the general hospitals down to the battalion level to train and work simultaneously. Informal but

¹⁶Quoted words from EUSAK, Report of ETMD, October 1952, pp. 29–30, file 350.05 (EUSAK) 1952, HRB. See also JLCOM, Reports of ETMD, April 1952, pp. 9–10, and March 1952, p. 32, file 350.05 (ETMD, Far East, JLCOM, 1952), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112, MMFB; Japan Logistical Command General Order 67, 19 May 52, MMFB; JLCOM, Annual Report of Medical Service Activities, 1952, pp. 67–68, file 319.1–2 (JLCOM) Far East–1952, HRB.

¹⁷JLCOM, Report of ETMD, September 1951, pp. 49–50, RG 112, MMFB; FEC, Annual Report of Medical Service Activities, 1951, pp. 104–05, HRB; JLCOM, Report of ETMD, July 1952, p. 27, file 350.05 (ETMD, Far East, JLCOM, 1952), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B,

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effective were sessions at the medical and dental societies that sprang up in Korea—the 38th Parallel Medical Society, the X Corps Medical Society, the Military Preventive Medicine Society of Korea, and the Korean Communications Zone Medical and Dental Society. Despite all its faults the system accorded people with interest and ambition an unusual opportunity to learn, for a wide range of teaching was open to all. Classes were well attended, indicating that many used their chance to learn new skills and hone old ones in study as well as practice.

Supply

While personnel fluctuated, supply became more dependable. Over the course of 1951–52 a steady influx of zone-of-interior materiel supplanted the rapidly dwindling World War II stocks. In some areas—notably pharmaceuticals—the capacity of Japanese manufacturers increased. In time, Army units were able to utilize sturdier American products. This did not, however, imply a loss of business for all Japanese manufacturers, because the needs of Korean relief mounted as the reconstruction of the country began under U.N. supervision. Additionally, supplies from all over the world arrived in the warehouses of the Japan Medical Depot, bound for the war-battered nation across the Korea Strait.

Another burden on medical stocks, both in the Far East and in the United States, resulted from the presence of increasing numbers of troops sent by other U.N. nations. Issues of medical supplies and equipment to U.N. forces increased in 1951 from about 3 percent of total issues in January to about 22 percent in October. As issues to the Republic of Korea (ROK) Army did not increase significantly, the diversion of supplies to other U.N. forces evidently caused the decrease in issues to U.S. troops from 94 to 75 percent during the same period.¹⁸

In 1951 medical supply operations divided into two phases, as the war did. Up to 10 July the war of movement, with continuous combat, meant high rates of usage. The opening of armistice talks at Kaesong, signaling the period of digging in and limited combat actions, meant lower consumption and, because materiel arrived from the zone of interior uninterruptedly, rising stocks in most goods. Until May the 6th Army Medical Depot at Yongdung-po remained the only supply organization in Korea itself; greatly overextended during the advance in late 1950, its scattered advance platoons benefited from the contraction of the front that followed the defeats of November and December. Subsequent advances underlined the need for a more elaborate system, and in May 1951 the 60th Medical Base Depot Company was activated at Pusan. In effect, the 6th and the 60th functioned as forward and rear support units, with the

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RG 112, MMFB; FEC and USAFFE and EUSAK, Annual Reports of Medical Service Activities, 1952, p. 48 and annex IV, pp. 7–8 and 14–17, respectively, HRB; Korean Communications Zone (hereinafter cited as KCOMZ), Report of ETMD, September 1952, p. 3, file 350.05 (KCOMZ) 1952, HRB.

¹⁸FEC, Report of ETMD, December 1951, p. 27, file 350.05 (FEC) 1951, HRB.

former serving the combat operations and the latter supplying the Pusan area, requisitioning from Japan, and operating as a transit depot. Located in small warehouses on the waterfront, the 60th by year's end was in process of acquiring newly constructed buildings for its work.¹⁹

Also in May 1951, the Japan Medical Depot moved from its old quarters in Yokohama, which the increasingly busy port authorities needed, to Camp Benda, 60 miles northwest of Tokyo. While stocks rose with shipments from the zone of interior, dependence on the Japanese economy continued, particularly for support of the ROK Army and for U.N. forces other than Americans. Textile deliveries for dressings were somewhat unsatisfactory, but Japan supplied many other items with success.

Striking was the growth of Japanese sophistication in laboratory work and the production of biologics. Early in the Occupation the Army had established tight quality controls over manufacturers to ensure high-quality products needed for civilian relief. In 1946 the civil government created a laboratory control section in the Ministry of Health and Welfare to set and enforce standards for the production of biologics. By May 1951, when Japan entered the World Health Organization, other Asian nations already were turning to the Japanese for advice and assistance in plant design and construction and for general technical know-how. In vaccines, sera, antibiotics (except for some of the newest), and human blood products, Japan was by this time supplying itself and a substantial part of the Korean civil assistance program as well. The Far East Command called Japanese production of penicillin "one of the sagas of the occupation." From the little that was turned out in laboratories at the end of the war, production on the islands rose to compete with the leading nations of the world: By 1951 the Japanese were making 15 trillion units a year. One sign of the nation's remarkable growth in expertise was the fact that the command routinely submitted drug supplies from U.N. nations to Japanese government laboratories for assay before including them in medical assemblies or shipping them to Korea for civilian relief.²⁰

Despite improvements in its sources of supply, the Japan Medical Depot was not without problems. By December 1951 the low level of combat had ended one nagging difficulty—there was at last an adequate supply of litters in the Far East Command—but short supplies were noted at various times during 1951 in a number of basic items: nitrous oxide (for lack of containers), plasma, field dressings, and blankets, among others. The tendency of medical supplies to leak away into Korea's civilian economy was a factor, notably in the case of blankets and of items like antibiotics, which brought high prices on the black market.

¹⁹FEC, Annual Report of Medical Service Activities, 1951, pp. 142–43; Surgeon's Circular Letter 6, no. 7, Medical Section, FEC, 1 Jul 51, p. 125, file 461 (Circular Letters) FEC; FEC, Report of ETMD, August 1951, p. 24, file 350.05 (FEC) 1951. All in HRB.

²⁰Quoted words from FEC, Annual Report of Medical Service Activities, 1951, p. 207, HRB. See also *ibid.*, pp. 200–12, HRB; JLCOM, Report of ETMD, June 1951, pp. 33–34, file 350.05 (ETMD, Far East, JLCOM, 1951), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112, MMFB; Toyko Army Hospital, 8059th Army Unit, Annual Report of Medical Service Activities, 1951, p. 45, file 319.1–2 (Tokyo Army Hospital, 8059th Army Unit) Far East–1951, HRB; EUSAK, Annual Report of Medical Service Activities, 1951, p. 79, HRB; *Civil Affairs/Military Government Public Health Activities*, p. 688.

"The many and varied uses to which some medical items may be *misapplied*," noted the FEC surgeon, "are too numerous to mention, and are usually quite well known to all concerned." Exactly where pilferage occurred—on the ships, in warehouses, on trains—is difficult to determine. On the whole, however, supply personnel were inclined to congratulate themselves on their success during the year that had seen a transition from the high usage rates and catch-as-catch-can methods of 1950 to a more sedate, elaborate, and well-ordered system. Few shortages lasted to the year's end, and 1952 held out some promise of putting the depots both in Japan and in Korea at last ahead of the game.²¹

As the front stabilized, signs appeared of a typically American abundance verging on excess. In this the medical supply situation was one aspect of a more general trend. Partly the situation was geographic; supplies entered but rarely left the Korean cul-de-sac. More important was the changing character of the war. Not only was combat less steady, but the American people sought to compensate the few who bore the burden of the fight by attempting to reproduce for their benefit at least some of the comforts of home. Ice cream machines, snack bars, theaters, and PXs began to dot the landscape, often surprisingly far forward. (Every soldier and marine was supposed to receive at least one serving of ice cream a week.) American troops enthusiastically seconded this trend. Commanders and men alike gathered into bunkers, camps, and unit areas as much impedimenta as they could to improve the quality of life. Wherever municipal water supplies became available, flush toilets, sinks, and shower baths followed. The official logistical history somewhat dourly warned that "it is the exception rather than the rule [in war] to provide telephones, space heaters, and PX radios in every squad bunker, or thousands of rounds of artillery fire to repel local enemy attack." Encased in body armor, longing for his rest and recuperation (R&R) leave, and counting the days to his rotation date, the American soldier comforted himself with consumer goods—a habit learned at home—while enduring an assignment that was still bleak and dangerous enough.²²

Transport reflected the new situation. The generally lower level of combat reduced the need for supplies, and its more predictable course meant that all medical supplies except whole blood, vaccines, biologics, and goods needed to meet sudden emergencies could be sent by sea. Transferred from the docks by truck to the medical depot in Pusan, materiel moved direct from the depot to U.N. troops in the area; to ROK Army medical depots; to the 25th Evacuation Hospital at Taegu, which supplied all U.N. units in that area; to the 171st Evacuation Hospital in Taejon, which filled the same role there; and to the 6th Army Medical Depot for distribution to troops in the Seoul area and to the advanced platoons at Uijongbu (I Corps), Chunchon (IX Corps), and Yanggu (X

²¹Quoted words from Surgeon's Letter 6, no. 7, Medical Section, FEC, 1 Jul 51, p. 125, HRB. See also FEC, Report of ETMD, September 1951, pp. 22, 25–28, file 350.05 (FEC) 1951; FEC, Annual Report of Medical Service Activities, 1951, pp. 144–45; EUSAK, Annual Report of Medical Service Activities, 1952, annex V, p. 4. All in HRB.

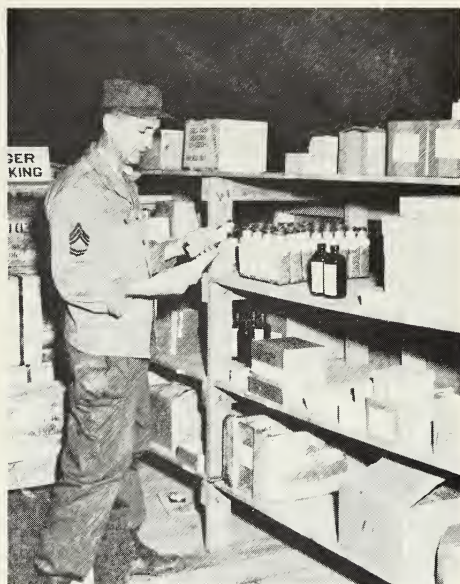
²²USAFFE and EUSAR, "Logistics in the Korean Operations," vol. 1, p. 11, RG 319, MMHB. See also FEC, Annual Report of Medical Service Activities, 1951, pp. 39, 74–75, HRB.

Corps). Supplies for UNCACK were turned over to the Korean Forwarding Company, a civilian concern, for shipment to another civilian establishment, the Korean Medical Company, a contractor with the South Korean government's Office of Supply.²³

From the Japan Medical Depot to the forward platoons, integration and quality of service improved steadily during 1952. No critical shortages occurred. An agreement with the Air Force led to a mutually satisfactory allocation of medical supplies between the two services in Japan. Procurement for the Army's needs from civilian sources was in decline throughout the year as shipments from the zone of interior more closely approximated needs. In 1951 about 50 percent of expendable supplies needed for the ROK Army and for POWs had come from

Japan; in 1952 the percentage was reduced to 15. But civilian aid procurements increased, not only because the relief program was expanding but also because they were cheaper and of constantly improving quality. The Japan Logistical Command boasted of a "very healthy relationship" between the Medical Service and Japanese suppliers. Clearly, it was healthy for the manufacturers. By the end of September they had sold \$4.5 million of goods, including \$2.8 million earmarked for Korean relief, to the Army for medical purposes alone.²⁴

Of considerable importance from the medical angle was the improving quality of food delivered to the troops in Korea. During much of the early fighting field rations were in short supply, and to conserve canned rations against need, the quartermaster shipped in fresh foods. The soldiers' taste for such items did not dissipate with the stabilization of the front, particularly as supply became easier. Troops continued to demand two hot meals a day, battle permitting. In the spring of 1952 over half the dinners and suppers served on the line were said to include some fresh meat. Some 20,000 tons of steaks, eggs in the shell, fresh potatoes, lettuce, and fresh fruit each month went northward from Pusan. Not only the Japanese hydroponic gardens but also refrigerator ships from the zone of interior brought the food in. Supplies were transferred to cold storage barges in the Korean ports and sent to the front by "reefer" cars on the trains of the 3d Transportation Military Railway Service. Technical improvements made even



CHECKING THE 6TH ARMY MEDICAL
DEPOT NARCOTICS SUPPLY

²³KCOMZ, Annual Report of Medical Service Activities, 1952, Encl 6, HRB. Relief activities are treated in Chapter 11 of this volume.

²⁴Quoted words from JLCOM, Annual Report of Medical Service Activities, 1952, p. 60, HRB. See also FEC and USAFFE, Annual Report of Medical Service Activities, 1952, pp. 75-76, HRB.

the dehydrated and canned foods, familiar from World War II, more palatable. Though 10 to 15 percent of the food shipments was lost to pilferage, American soldiers probably ate better in Korea than even their own well-nourished predecessors during most of the Second World War.²⁵

Food supply was, of course, a Quartermaster responsibility, but members of the Veterinary Corps continued their accustomed work as food inspectors. (Their other duty, caring for Army animals, was minimal because the only ones in the command were 144 war dogs, of which 7 were in Korea at the end of 1951; furthermore, the health of the dogs was very good.) Food inspection work, by contrast, was heavy. In one month taken at random—January 1952—nearly 793 million pounds of food had to be inspected; over 850,000 pounds were rejected. Besides the imports from the United States a variety of food—including fruit, swordfish, vegetables, recombined milk, and ice cream—was produced in Japan, though only the fruit and fish came from Japanese sources. To carry out inspections, by the end of 1951 thirteen veterinary units operated in Japan and six in Korea.

The feeding of an international force presented unique challenges to all concerned. The ROK Army ate only one large meal a day—an Oriental ration of fish, kelp, rice, and beans—but snacked at other times, and exhibited a boundless appetite for hot peppers. Inspectors baffled by Korean labels on canned goods sometimes found their Korean assistants as helpless as themselves; educated under Japanese rule, they could read that tongue but not their own. Turks would eat pork in battle or in camp, but in hospitals often felt religious qualms and refused it. Greeks preferred their own food but would eat American rations, if pressed. (A request from a Greek Orthodox priest for “virgin” lambs for Easter was met with young male lambs, “which proved entirely satisfactory.”)²⁶ Because many supplies, especially for the Koreans, came from Japanese sources, veterinary officers had to learn the names of Japanese fish, of which there were altogether too many, and to accept the fact, difficult for American sensibilities, that the penicillin-like mold that grew on air-dried fish was harmless.

Though surprised by such variations in military service where standardization was the rule, the Army tried to meet the tastes of its allies as far as possible, obtaining from Japanese producers a porkless ration for Moslems and a standard oriental ration that met ROK Army tastes. The chief questions remaining about the latter were its nutritional value, and, after it passed out of American hands, its distribution to the troops on the line.²⁷

The depletion of World War II stocks, increased zone-of-interior shipments, and the shift of local goods to the relief program reshaped the supply picture

²⁵Samuel Milner, “Time and Space,” ch. 5, p. 136, Ms no. 2–3.7B AA, RG 319, MMHB. On continued veterinary food inspection work, see FEC, Annual Report of Medical Service Activities, 1951, pp. 38–45, HRB.

²⁶JLCOM, Annual Report of Medical Service Activities, 1951, p. 115, HRB.

²⁷Above paragraphs are based on *ibid.*, pp. 112–16, HRB; FEC, Annual Report of Medical Service Activities, 1951, pp. 38, 41–45, HRB; Ltr, Headquarters, JLCOM, to Commander in Chief, FEC, sub: Organization of Veterinary Food Inspection Detachments, Encl to DF, Medical Section, JLCOM, to Staff Sections G–4, G–3, C/S, AG, JLCOM, 21 Nov 50, tab 2, document 14, Medical Section, JLCOM, Command Report, 1–30 Nov 50, Narrative Summary [and Documents], file

during 1952. Reduced fighting, growing accumulations in the using units and the maturing of the transport system changed the character of the soldier's experience. The lot of the fighter in any war is by definition harsh, but by that low standard American soldiers in Korea had passed from the chaos of mid-1950 to relative prosperity. The static front, control of the air, and the nature of the war itself had brought them to a "pampered" state that critics deplored but did not offer to share. The medical system kept pace, delivering sophisticated equipment like electrocardiograph machines to forward hospitals and maintaining a steady flow of all necessities to the front in a war that now had become, and seemingly might long remain, part of the order of things.

The Blood Program

No single medical item was more important than blood, and its supply was a specialized program stretching from the zone of interior to the battlefield. Basic both to its value and to many of the problems encountered in handling it was the fact that whole blood is a living tissue, obtainable only from human subjects. To be usable, blood had to be treated to prevent clotting, stored at 38°–42°F, and used within twenty-one days. During transport it had to be handled carefully to prevent the oxygen-carrying red cells from being destroyed. A part of the body of the donor, and consequently reflecting his state of health, both whole blood and plasma (the fluid part of the blood) had to be carefully controlled to prevent the spread of disease. Because the results of new tests revealed that the danger of transmitting serum hepatitis was much greater than previously realized, the use of plasma during the Korean War tended to give way to serum albumin and synthetic plasma expanders. The lifesaving qualities of whole blood, however, were so remarkable that its use grew steadily, though no means of sterilizing it were known.²⁸

The year 1951 saw the blood program established during the first months of the war grow and matured. In September the secretary of defense set up the Armed Forces Blood Donor Program, with centers at thirty-one major military installations across the country. The Red Cross rapidly increased its own capacity to obtain and process blood. Plasma-processing plants were operating at full capacity. Blood collections continued high well into 1952, but fell off in May. In October, responding to the fierce fighting of that month, they rose again, only to fall thereafter in response to the general national disillusionment with the war. Throughout, the Red Cross supplied about three-fourths of the blood, the armed services the rest. Besides obtaining blood the laboratories typed and otherwise classified it, and processors salvaged serum albumin from blood unsuitable for

AYUT-8000, Annex 24 (Medical Section, JLCOM, Nov 50), Box 4623 (JLCOM, AYUT-8000, Annexes 19-28, Nov 50), Entry 429, RG 407, MMFB.

²⁸This section is based upon the following sources: Kendrick, *Blood Program in World War II*, pp. 713-806; copy of Article, Lt Col Spurgeon H. Neel, Jr., MC, Commander, 30th Medical Group, "Forward Distribution of Whole Blood," HSF (Neel Articles), HRB; Supply Division, OSG, Summary of Major Activities, 9 Sep 51-31 Dec 52, pp. 1-2, file 314.7-2 (Army Medical Service Activities, 9 Sep 51-31 Dec 52), HRB.



MEDICS ADMINISTERING
BLOOD PLASMA

plasma, from overage blood, and from contaminated plasma. From the zone of interior, Type O blood, especially the low titer universal donor variety—so called because it caused fewer problems than other nonmatched types when administered to Type A and Type B recipients—was shipped to the Far East, most of it being sent on from the 406th Medical General Laboratory to Korea.

Once in Korea blood moved through the supply system much like any other critical item, though medical officers often called for special treatment of a most unusual and fragile substance. In medical depots blood was stockpiled and the oldest that was usable issued to the hospitals—a reasonable arrangement but one that tended to increase the age of the blood by the time it got into the recipients'

veins. With nine or ten usable days left for most when it reached Korea, the blood actually transfused was from nine to twenty days old.

Air transport was the key to the successful forward use of whole blood. Blood was flown by the Military Air Transport Service (MATS) to Travis Air Force Base in Oakland, California. Here the Armed Forces Blood Processing Laboratory examined and repacked it. MATS planes then carried it via Hawaii and Wake Island to Tokyo. Again traveling by air to the depots at Pusan and Seoul, and by fixed-wing aircraft or helicopter to the forward depot platoons in the corps areas, containers of blood completed the journey to the MASHs on medevac helicopters, strapped into the pods like casualties. As with casualties, the two great advantages of air travel were speed and smoothness. Blood arrived in time and in condition to be used, which was not always true after spending hours or days in transit over the cocktail-shaker Korean roads. Though wastage occurred, in considerable part because of the widely fluctuating needs of the front once the static phase of the war began, the Far East Command judged the blood supply system on the whole an "extreme success" and a continuing key to the remarkable survival rates in the hospitals of both Korea and Japan.²⁹

The problem of hepatitis in plasma proved, however, insoluble during the Korean War. Armed with new tests for detecting subclinical hepatitis, hospitals in Korea found rates that reached 23 percent among men who received multiple transfusions of plasma and whole blood. Investigations by the Armed Forces

²⁹FEC and USAFFE, Annual Report of Medical Service Activities, 1952, pp. 41–42, HRB.

Epidemiological Board and the National Research Council showed that ultraviolet radiation did not destroy the virus in plasma. Unlike whole blood, plasma had no oxygen-carrying ability and functioned in hemorrhaging patients merely as a filler for the vascular system, preventing a disastrous fall in blood pressure. The problems with plasma turned the attention of investigators to other blood substitutes that might accomplish the same goal with less risk. Serum albumin, a natural protein prepared from blood or plasma, proved to have marked advantages. It was not infectious and could be stored easily and used by medics in the field to stabilize the wounded for their journey to a MASH, where whole blood was available. Another substitute was Dextran, a commercial product made from sugars that increased the fluid within the vascular system by drawing it from the surrounding tissues. Despite its dehydrating effect it too proved useful, especially to unit aidmen and in battalion aid stations. By such means the Medical Service attempted to minimize the problem of secondary infection until a conclusive answer was found.

Preventive Medicine

Apart from the baffling mystery of serum hepatitis, spread by the very transfusions that saved life, the record of the medics was generally one of improving control over the sources of disease, even hemorrhagic fever.³⁰ The other form of hepatitis—the infectious variety that was endemic in Korea—reached near epidemic proportions during 1951. But change was on the way. The Army had developed an iodine water purification tablet shortly after World War II but had hesitated to employ it because of fears that it might prove toxic. Tests showed, however, that ingestion of the amount needed was not harmful, and as a result Halazone tablets, long proved unsatisfactory after storage, were withdrawn and iodine tablets issued.

Chlorine also continued to have value in water purification. Troops located near municipalities increasingly drew their water from civilian supply systems and adding chlorine provided a margin of safety. In the Eighth Army, the standard field requirement rose from 1 to 5 parts per million. In response to this change, and to the slackening of combat that enabled troops to drink treated water, the infectious hepatitis rate fell from 33 to 12 cases per 1,000 per annum. With canteen water disinfected, engineer water supply points multiplying, and municipal supplies hyperchlorinated, hepatitis and many enteric diseases as well were brought under better control during late 1951 and 1952 than at any time since the outbreak of fighting.³¹

Control of pests and disease vectors generally improved, though with one or two exceptions of note. Insect and rodent control in Korea was carried out by one preventive medicine company and a number of smaller units. The larger

³⁰As a problem mainly of the forward areas, epidemic hemorrhagic fever is treated in Chapter 6 of this volume.

³¹FEC, Annual Report of Medical Service Activities, 1951, pp. 65–66; extract from TSG Notes no. 8, April 1954, p. 7, HSF (TSG Notes–1954). Both in HRB.



DUSTING FOR MOSQUITOES *with an improvised device*

unit—designated the 37th Preventive Medicine Company after reaching the Far East—was a new type of organization that quickly demonstrated its value. Serving with the IX Corps, the company provided one control section for each division; its members conducted training sessions for the troops, mixed and provided poisons, carried out field work, made sanitary inspections, and collected water samples and insect specimens for testing. The company's officers were entomologists or sanitary engineers, and its enlisted men had received training in one or more phases of preventive medicine. The company proved so useful an innovation that the Medical Service began to train a second in the zone of interior.³²

In cooperation with the Air Force, planes were used in what the Far East Command called the “largest military spray program ever conducted.”³³ Under Maj. William M. Wilson, four aircraft began to fly missions in June 1951, spraying a 20-percent DDT emulsion over some 370,000 acres. Repeated flights were necessary to suppress insect (especially fly) populations, which tended to rise quickly after each treatment. Major cities and airfields were the favored targets, with special missions to the Munsan peace conference area. As usual, it

³²FEC, Annual Report of Medical Service Activities, 1951, pp. 60, 67, HRB; “New Type of Army Medical Company,” *Military Surgeon* 108 (January 1951): 65–66.

³³FEC, Annual Report of Medical Service Activities, 1951, p. 67, HRB.

was difficult to separate the various factors influencing disease rates. Malaria, for example, peaked in early summer at a rate of only 18 cases per 1,000 troops per annum, markedly lower than its maximum of 31 the year before. Possible causes included the fact that prophylaxis was more rigorously enforced, that weather was unfavorable to mosquitoes, that ground sprayers were at work as well, and that the new face of the war separated combatants from civilians more completely than before. Whatever the reason, diseases borne by insects and other arthropods were markedly less important than in the past. One serious disease, Japanese B encephalitis, almost disappeared.

Unfortunately, malaria became a problem in Japan as it ceased to be one in Korea, for returning personnel infected the local anophelines, which in turn attacked a population with little natural resistance. Troops returning to the zone of interior also had frequent relapses on shipboard, a sharp reminder of the fact that chloroquine suppressed the symptoms of malaria but did not kill the parasites. In December the new antimalarial primaquine came into use, a promising innovation because tests indicated that it killed the *Plasmodia* in the tissues of victims.³⁴

The environmental dangers of using broad-spectrum insecticides were little appreciated at the time. Soon, however, it became apparent that body lice in Korea—probably because of immunity developed during earlier spray campaigns—were becoming DDT-resistant. At first medical personnel thought that the DDT in use must be old, and they obtained freshly made supplies. When the new DDT also proved ineffective, search for another insecticide began, with the specter of possible typhus epidemics to encourage speed. Experiments in Korea during the summer of 1951 included new reliance on an old standby, pyrethrum, and trials of 1-percent lindane (benzene hexachloride), then in agricultural use in the United States. Lindane proved effective, and by the end of the year the 38th Preventive Medicine Control Detachment reported that two applications reduced the lice problem among some POWs—the worst afflicted group in Korea because of initial infestation, crowding, and restricted movement—from 92 to 0.9 percent. Meanwhile, studies in Japan showed again a highly specific resistance in lice to DDT, further evidence that the substance, for almost a decade the nuclear weapon of the war on noxious insects, was losing its punch.³⁵

Other diseases demanded quite different methods of control. In December 1950 the surgeon general had warned of a possible influenza epidemic in Korea, and by January 1951 the case rate had risen in the Far East Command to 203 per 1,000 troops. On 22 January the command ordered all U.N. troops immunized against influenza. Thereafter the disease fell off, though rates throughout the command remained higher than in 1950. Venereal disease (VD), as usual, showed an inverse relationship to the level of combat, rising in Korea as the front stabilized and the intensity of fighting fell. Narcotic addiction was reported a problem in some parts of Korea, reflecting the ready availability of both marijuana and heroin. Poliomyelitis was relatively more common, the bulbar form in particular exhibiting a high mortality rate, and tuberculosis began to

³⁴Ibid., pp. 51–52 and 67–68, HRB.

³⁵FEC, Annual Report of Medical Service Activities, 1951, pp. 69–72, HRB.

rise among Americans in both Korea and Japan. Probably for genetic reasons, blacks were especially susceptible. No disease, however, was of major military importance.³⁶

Overall, the changes that appeared in the disease picture during 1951 reflected, not medical innovations, but political and military events. The signing of the Japanese peace treaty meant more contacts between Americans and Japanese and consequent dangers to both. In Korea the stabilization of the front drastically altered the possibilities of preventive medicine and, as the rise in VD rates showed, increased the prevalence of some ills while enabling medics to suppress others more effectively. The rotation system, R&R leave, and the introduction of dependent travel to Japan all produced movements of people that implied the spread of disease. When all was said and done, however, the positive signs far outweighed the negative.³⁷

The following year saw many of these trends continue and intensify. The activation of the KCOMZ brought into being a headquarters where preventive medicine throughout the rear areas was a matter of major concern. At the end of 1952 the command reported that the health of the troops was, all things considered, amazingly good. Systematic immunization, begun in 1950 and carried on through 1951 and 1952, was basic to the soldiers' ability to resist the local disease environment. Increasing numbers now were housed in permanent or semipermanent quarters. Messing facilities were good, and the men themselves were said to be showing considerable self-discipline in avoiding contaminated water and food, in great measure because their own rations were palatable and commissary liquor was abundant and cheap.

Another key to success was the fact that the KCOMZ by this time had four preventive medicine units operating within its boundaries: the 38th, 152d, and 154th Preventive Medicine Control Detachments, and the 219th Preventive Medicine Survey Detachment. The 38th was assigned to the Prisoner of War Command and the 152d to the Korea Base Section. The 154th, headquartered in Pusan, supplied groups of one to five technicians for special assignment to meet local problems, and the 219th served the entire KCOMZ. Upon these units fell the responsibility of controlling what the command surgeon called the "entomological theater" of Korea, performing work similar to that of the preventive medicine company in the forward areas.

The two great medical problems of the forward areas—hemorrhagic fever and cold injury—were nonexistent in the communications zone. The main exceptions to the generally happy picture were infectious hepatitis—much reduced by chlorination but still too high—and that traditional problem of the zone, venereal disease. The command surgeon traced the continued incidence of hepatitis to three factors. Most, he noted, occurred in the Pusan area, a center of the drug traffic and drug addiction, and he raised the question of whether the

³⁶EUSAK, Annual Report of Medical Service Activities, 1951, pp. 20–21, HRB.

³⁷FEC, Annual Report of Medical Service Activities, 1951, pp. 57–59; Ltr, Col C. C. B. Warden, Adjutant General, FEC, to Commanding General, JLCOM, et al., 11 Aug 52, sub: Reciprocal Reporting of Communicable Diseases Between United States Armed Forces in Japan and Japanese Health Authorities, app. II, Preventive Medicine Division sec., FEC and USAFFE, Annual Report of Medical Service Activities, 1952, HRB.

two might not be connected. Occasional slips in personal discipline, primarily from drinking nonpotable water or eating seafood or fruit displayed in the street stalls and markets, might also be a source. Finally, and seemingly most important in his eyes, he cited the large and increasing use of Korean food-handlers in messes, clubs, snack bars, and railroad diners. Many surveys had shown that Koreans of the laboring class were all parasitized in some degree; it seemed reasonable that such people might be a source of hepatitis as well.

As for venereal disease, rates were high and climbing, in 1952 jumping between September and November from 176.8 cases per 1,000 troops per annum to 202. The KCOMZ began to construct prophylactic stations in Korean cities, sought wider cooperation from South Korean authorities in treating the civilian population, set up a Public Health Advisory Council composed of medical officers from its major commands, and began trials of oral penicillin therapy in hard-hit Taegu. The usual calls for "wholesome entertainment" for GIs were heard again. The zone surgeon found fundamental problems, however, in the extraordinary number of prostitutes, both registered and unregistered. Korean authorities followed traditional practice by informally licensing brothels and inspecting their inmates; the U.S. Army's policy of either breaking up houses of prostitution or putting them off limits, Koreans pointed out, merely drove women into the streets and put a premium on uncontrolled streetwalking. The Americans countered that actual Korean practice was extremely haphazard, with insufficient treatment of diseased women and poor contact tracing. Because both accusations were probably true, and because the military and civil authorities were at loggerheads over policy, the prospects for improvement in VD rates did not, at year's end, appear to be very good. It was also true that infection on the average of one man out of five once a year did not, with antibiotic therapy, represent a very serious drain on job performance.³⁸

Psychiatry in the Korean rear areas showed trends which fitted in well with the patterns of physical disease. Neuropsychiatric disorders in the KCOMZ were higher than in the American Army as a whole, though "not . . . excessive" in the judgment of the zone surgeon. Among causes he cited the "boredom of service in Korea," which certainly had not been a difficulty during 1950. TDY to Japan came too seldom; places for sightseeing, given the continuing presence of guerillas, were few. He noted, however, that the shortage of "hobby shops, day rooms, special service activities and equipment, service clubs and the like" was rapidly being corrected. The nature of the war was probably the root problem in that a sense of futility underlay many apparently superficial complaints. American soldiers simply did not feel any longer that they were part of a significant endeavor. Against this background the erratic supply of replacements and lack of promotions caused serious morale problems, for every revision in the point score for rotation had "a shattering effect." Such changes were, of course, particularly noticeable in the rear areas, because the Far East Command, if faced with a shortage of replacements, would lengthen the time of service

³⁸Above paragraphs are based on KCOMZ, Annual Report of Medical Service Activities, 1952, encl. 3, pp. 1-2 and 4-7, HRB. The hepatitis associated with drugs was actually serum hepatitis spread by infected needles.

troops rather than that of men on the line. What the headquarters found to be—and in fact was—reasonable and just often appeared to those affected as a heartless “manipulation” of rotation dates. Meanwhile, the well-nourished monotony of military life was surrounded by the “squalor, poverty, wretchedness, malnutrition and disease” of a wrecked and ravaged land—a comfortless prospect.³⁹

Narcotic addiction raised minor furors in the press every few months, though the Far East Command judged the rate to be “not . . . anything alarming.” However, heroin was cheap in Korea—between eighty and ninety cents for about 65 milligrams—and was the most commonly used hard drug. A fair percentage of users did not appear to be addicts but rather exhibited a social pattern of indulgence, similar to the ordinary use of alcohol, which the command found surprising. Use in Korea was spotty, “two or three persons in some companies with four or five hanger-ons [*sic*].” Aside from suggesting that a field for research might exist, the neuropsychiatric consultant apparently found no cause for concern in the phenomenon.⁴⁰

Dental Care

The dental service reflected the tendency toward improved care. The armed forces had 2,358 dentists on 1 July 1950 and 5,729 one year later. In the Far East Command the number of dentists, with few exceptions, was adequate; but for a very few months, Eighth Army figures hovered within 5 percent of the authorized strength. Replacements were sufficient in numbers, though sometimes spasmodic in their arrivals. Normally, new men requested and received forward duty, often at division level, in order to earn rotation points as quickly as possible and to finish their military tours in more agreeable locations than Korea. Customary problems remained in the lack of adequately trained enlisted men, especially well-qualified dental laboratory technicians. Replacements often arrived at their assignments with long-neglected mouths that required lengthy work in the dental chair and prostheses. A survey in late 1952 on replacements in a field artillery battalion showed that 6.5 percent needed emergency treatment, 15 percent prostheses, 43 percent immediate treatment of advanced dental conditions, 33 percent preventive or corrective action, and only 16 percent no dental work at all. Such conditions, the result of personal reluctance to face the dentist as long as possible plus the Army's failure to survey and treat men adequately before shipping them overseas, needlessly burdened the Far East Command. They were, however, quite in line with the experience of earlier years.⁴¹

³⁹*Ibid.*, p. 3, HRB.

⁴⁰First quotation from FEC and USAFFE, Annual Report of Medical Service Activities, 1952, p. 89, HRB. Second quotation from MFR, Wayland L. Speer, Chief of Narcotic Control Bureau, Public Health and Welfare Division, Medical Section, SCAP, 26 Jun 51, sub: Staff Visit to Korea by Chief, Narcotic Control Division, p. 3, file Korea–Narcotics, Box 3178 (Public Health and Welfare, Medical Section, FEC, Korea–Civil Affairs to Korea–Relief and Welfare), RG 338, MMFB. See also Ltr, Speer to Commissioner H. J. Annslinger, Bureau of Narcotics, Treasury Department, 27 Jul 51, file 441.1 (Narcotics), Box 3171 (Public Health and Welfare, Medical Section, FEC, 1951), RG 338, MMFB.

⁴¹Extract from Office of the Secretary of Defense, Annual Report of the Armed Forces Medical

With the stabilization of the front, dentists began to do a great deal more dentistry and less emergency filling in for surgeons. The general tendency was to increase dental staffing forward. During 1952 one oral surgeon was attached to each of five MASHs to give added support to front-line units. Each of the Eighth Army's two evacuation hospitals had one dentist and one oral surgeon. Evacuation hospitals provided some outpatient services, and the MASHs made their X-ray facilities available for unit dental officers in their areas. In the divisions of the Eighth Army all eighteen Dental Corps officers were assigned to the medical battalion but were attached to various units as the situation might require. Usually, one dental officer was needed in each regimental collecting

station, in the replacement company, and in the division headquarters. Battalions serving in difficult or remote locations often received their own dentist, principally field artillery and antiaircraft units and combat engineers. The division dental clinic was an innovation that was proving itself in practice.

Additionally, the Eighth Army had in the 163d Medical Battalion an organization that provided, among other functions, a dental service throughout the Army area. The battalion controlled several dispensaries, eleven dental operating detachments, and a dental prosthetic detachment. The battalion took up any slack by sending help to needy units.

In the field the lot of the itinerant dentist was often difficult, strapped for shelter and for electric power to run his lights and drill. Dentists permanently attached to units showed considerable skill at digging in. Their tents were framed and floored and usually set into the south slope of a hill, or against the defilade of an east- and west-running ridge. Where possible, dental officers used bunkers solidly constructed of logs, railroad ties, or bridge timbers. The framed semicylindrical Jamesway tent (usually called "Janeway") was, however, a dark place when several sections were joined together, for the only windows were on the ends. Except for the mobile prosthetic units that carried their own power source, dentists were dependent on an outside source for electricity, or on small portable generators that often worked poorly. With a chair, his dental field



FORWARD DENTISTRY

Policy Council to the Secretary of Defense, pp. 6-7, HSF (AFMPC-1951), and from *ibid.*, sec. 13, tab 34, p. 168, file 334 (AFMPC, 30 Dec 49-1 Apr 53), Box 24, RG 112, MMFB; EUSAK, Annual Reports of Medical Service Activities, 1951 and 1952, p. 36 and annex IX, pp. 1-9, respectively, HRB.



INTERIOR OF A JAMESWAY ("JANEWAY") TENT

operating chest, and electricity, the Dental Corps officer was ready for work, of which there was seldom any lack.⁴²

Dentists assigned to rear areas had little to report after 1950, except the familiar problems among replacements and dependents and ongoing improvement of facilities. In Japan, clinics and dispensaries tended to remain in one place for lengthy periods, adding to the increased sense of regularity and order among those who worked in them. The number of dentists was adequate, and the rapidity of air evacuation from Korea enabled the dental consultant to recommend primary closure of maxillofacial wounds after temporary debridement—an important matter from a cosmetic standpoint because early wound closure resulted in less scarring. Oral surgeons usually found wounds fresh and uninfected, and their own numbers were adequate to the lessened casualty load.⁴³

⁴²EUSAK, Annual Report of Medical Service Activities, 1952, annex IX, pp. 1 and 6, HRB.

⁴³JLCOM, Annual Report of Medical Service Activities, 1952, pp. 71–78, HRB.



MILITARY AND CIVILIAN CONSULTANTS. *Left to right: Col. John M. Salyer, Lt. Col. Haskell K. Ziperman, Dr. Edward D. Churchill, Brig. Gen. L. Holmes Ginn, Jr., Dr. Paul W. Sanger, Lt. Col. William S. Cornell, Col. Oral B. Bolibaugh, and Col. Joseph R. Shaeffer.*

Of Professional Interest

The work of the FEC consultants continued along familiar lines, interviewing newcomers, recommending assignments in their own specialties, and carrying out tours of inspection. Instruction remained a basic duty, the consultant's lectures deriving much of their influence from his professional reputation, experience, and expertise, rather than from his position in the military hierarchy. The consultant's manner toward more junior physicians and surgeons was clearly derived from the tradition of ward rounds in teaching hospitals. The surgical consultant wrote in 1951 that

during visits to hospitals, professional ward rounds were made with members of the surgical staffs. At all times the Consultant assumed the attitude of a friend and counselor who was willing and desirous of being of help professionally. Suggestions were made in difficult or complicated cases. Mistakes . . . were brought to the attention of those responsible, in a spirit of friendliness . . . to the end that the Consultant (at least, so we

sincerely hope) was looked upon, not as an inspector or fault finder, but as a colleague having a paramount interest in the welfare of the patient and in the service.⁴⁴

Youth and inexperience in military surgery characterized most of the huge number of new men who arrived during 1951, obliging the consultant to distribute the "sprinkling of Board eligible and Board certified officers . . . as well as possible throughout the Command."⁴⁵ Whenever possible, new surgeons were assigned to hospitals in the Japan Logistical Command before being sent to Korea. Here they could learn from both veteran soldiers and men returned from the battlefield and could observe at firsthand the consequences of proper and improper procedure in forward hospitals. No consultants as such were assigned to the KCOMZ; specialists working there doubled as consultants. Frequent visits from those in Japan provided an attraction for the monthly meetings of the Korean Communications Zone Medical and Dental Society, held at Pusan, Taegu, and Taejon.

Deficiencies in the supply of critical specialists continued, mitigated by the reduced work load. Rising numbers of orthopedic surgeons during 1951 combined with lessening combat activity to make a continuing shortage less acute. General surgeons were trained in orthopedic procedures and, reassigned to the MASHs, in many instances did outstanding work. Changes on the battlefield and the rotation policy directly affected the nature and quality of surgical work. The advent of body armor noticeably reduced injuries to the trunk and increased proportionally the number of wounds to the extremities. Artillery duels across the entrenched lines meant increased injuries from shell fragments, also mostly to the extremities, for even when fragments penetrated the armored vests, the wounds were usually quite superficial. Chest injuries tended now to be the result of crushing forces, such as the blast effect of nearby explosions, or the result of direct impacts from high-velocity missiles. In October and November 1952 a large number of men with infected wounds reached the hospitals in Japan. The reason was not only the increased combat during October but also the arrival in the Eighth Army and the KCOMZ of a large number of surgical replacements with hardly any experience in the treatment of massive traumas in a septic environment. The patients were inadequately debrided, and at least two required lower extremity amputations that should not have been necessary. Energetic activity by the FEC orthopedic consultant and the Eighth Army surgical consultant—with frequent lectures and demonstrations—apparently ended the problem by mid-November.

The general lessening of combat allowed patients to be held longer in the theater and more elaborate procedures to be undertaken. Generally speaking, the duties of forward hospitals in handling wounds were to perform adequate debridement, leaving most wounds open; to stop bleeding; to treat shock; and to prevent infection. In the KCOMZ every effort was made to close wounds as

⁴⁴FEC, Annual Report of Medical Service Activities, 1951, pp. 15–16, HRB. Quotation on p. 24.

⁴⁵Ibid., p. 25, HRB.

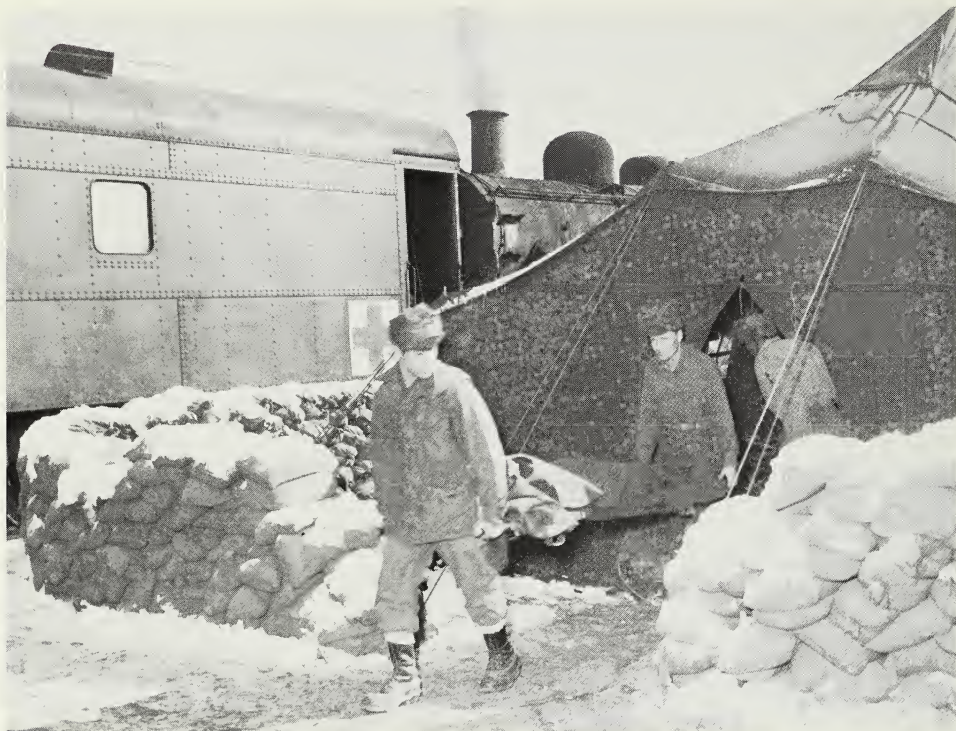


MEN AT WORK IN A SURGICAL RESEARCH TEAM LABORATORY

soon as possible after the fifth day. Physical therapists worked closely with orthopedists to restore function to injured limbs. Fracture victims could now be held long enough for callus—a flexible tissue formed by the body as the first stage in healing a break—to form, avoiding complications caused by attempts to move the patient prematurely. Nailing, or pinning, of broken long bones was routine. Though no attempt at elaborate reconstructive surgery was made in the theater, treatment of chest wounds had become so effective that only occasional evacuations to the zone of interior were necessary. For all wounded who reached medical installations, the mortality rate declined from World War II's 4.5 percent to 2.1 percent in 1951 and again to 1.8 percent in 1952.⁴⁶

Research teams continued to visit Korea, bringing and seeking new ideas, methods, and data. In 1951 the Office of the Surgeon General's Research and Development Board listed nine: in surgery, anesthesia, wound ballistics, cold injury, field investigation, malaria, DDT-resistant lice, dysentery, and hepatitis. The malaria team's primary function was to study primaquine; that of the hepatitis team was to study the hospital management of the patient. Studies by the wound ballistics team led to more rigorous enforcement of the rule that steel

⁴⁶*Ibid.*, pp. 18, 25–26, HRB. See also *ibid.*, 1952, pp. 38–39, HRB. Rates for 1950 do not appear in the records, due to the chaotic conditions of the time.



LITTERBEARERS CARRYING CASUALTIES TO A HOSPITAL TRAIN

helmets were to be worn by combat troops at all times. Methadone as a morphine substitute was still undergoing trials, which generated favorable reports. The field investigation team aimed to pinpoint important field medical and surgical problems. A practical result of its efforts was the introduction in 1951 of a new field dressing for wounds and burns.

The surgical research team was especially prolific in its studies of the clinical management of war casualties. Though research in combat theaters dated from World War I, it was further systematized in Korea as a policy of the Medical Service and the Department of Defense. Under Dr. Fiorindo A. Simeone of Western Reserve University and later under Capt. John M. Howard, the team found a home at the 11th Evacuation Hospital on the relatively quiet eastern sector of the front. Here and at the MASHs team members practiced and taught arterial repair and also studied kidney and liver damage, burn treatment, and other types of wounds. Emphasizing the dynamic and pervasive effects of wounding, Howard and his colleagues helped to make the Korean War a landmark in battlefield medicine.⁴⁷

⁴⁷FEC, Report of ETMD, June 1951, p. 29, file 350.05 (FEC) 1951, HRB; Medical Research and Development Board, OSG, History of the Korean Conflict: Summary of Activities, 25 Jun 50–8 Sep 51, p. 3, file 314.7–2 (Army Medical Service Activities, 25 Jun 50–8 Sep 51), HRB; Howard, *Battle Casualties in Korea*, 1:1–12. Accounts of some specific contributions by the team are given in Chapters 6 and 7 of this volume.

The Flow of the Wounded

All these varied activities had meaning, of course, only in the flow and treatment of the wounded. Though increasing numbers stayed in Korea, many continued to be carried by air or sea to Japan and the zone of interior. During 1951–52 the railways remained the most important means of evacuation within Korea, while movement out of the country became more dependent on air transport than ever before.

Rail evacuation might begin as far forward as the clearing station, if tracks were nearby and the tactical situation permitted. When a line was available, ambulance buses were attached to the medical battalion. Fitted with additional flanged wheels for travel on the rails, the buses also could move on the roads to and from the rail line in case of need. With the stabilization of the front, tracks were extended northward in the I Corps zone to within 8,000 yards of the front line. By late 1951 sixty-two hospital ward cars were reported to be working in Korea. The standard train now consisted of thirteen cars—eight ward cars, a kitchen, dining room, and pharmacy car, an officer personnel car, two orderly cars, and one utility car. Maintained and operated by Transportation Corps personnel and staffed by the Medical Service, the trains evidently had come a long way from the rough early days of medical railroading in Korea. With the organization of the KCOMZ, control of the railroads passed to the new headquarters, but the Eighth Army reported at the end of 1952 that the “*evacuation* system has changed very little during the year.” In terms of function and relative dependence upon the different modes of transport, the estimate seems fair.⁴⁸

Evacuation from the Army area into the KCOMZ was by train or plane. Ambulance convoys brought the wounded to railheads, where they passed into the hands of the communications zone, or to airfields for flights to the zone or Japan. Assigning the wounded to the proper hospital continued to be the function of the medical regulating officer at Pusan. In mid-1951 Lt. Col. Vincent J. Amato of the 52d Medical Battalion explained the medical regulating officer’s duties: He must be thoroughly familiar with the regulations, with the facilities, and with the specialties of the various hospitals; he must keep a list showing the location of special equipment (eye magnets for removing metal fragments, iron lungs, EKGs, to name a few); and he must know what languages were spoken in the various hospitals so that, if possible, a U.N. soldier might find himself in a unit with nurses or at least an interpreter from his own country. Armed with this information, the medical regulating officer confronted the inflow by train and plane. While the most serious cases were being unloaded first, the officer, using advance data on the makeup of a particular group of wounded, conferred with accompanying doctors and nurses and began to make hospital assignments on the basis of available bed strength and specialty.⁴⁹

⁴⁸Quoted words from EUSAK, Annual Report of Medical Service Activities, 1952, p. 5, HRB. See also *ibid.*, 1951 and 1952, pp. 6–9 and annex IV, pp. 6, 8–11, respectively; I Corps, Annual Report of Medical Service Activities, 1951, p. 3, file 319.1–2 (I Corps) Far East–1951. All in HRB.

⁴⁹Surgeon’s Circular Letter 6, no. 7, Medical Section, FEC, 1 Jul 51, pp. 126–27, HRB.



CASUALTIES ON A HOSPITAL TRAIN HEADED SOUTH

Rear area hospitals underwent considerable change in response to the lower level of fighting. At the end of October 1951 the 21st and 22d Evacuation Hospitals, Semimobile, replaced the 3d and 10th Station Hospitals, respectively, and the 25th Evacuation Hospital replaced the 4th Field Hospital. Ironically, during 1952 the rear area hospitals changed unmistakably into settled installations providing area care. Though their titles suggested semimobile organizations, part of a system of emergency medicine geared to quick evacuation, their functions approximated more and more closely those of conventional station hospitals.⁵⁰

As the MASHs had evolved into general-purpose forward hospitals, the evacuation hospitals in their turn grew as omniscient backup facilities. Lack of a medical field laboratory in EUSAK compelled hospitals to perform more elaborate tests than their T/O&Es contemplated and led to recommendations for expanded laboratory facilities. Evacuation policy shifted frequently, but the long-range tendency was for the time limit to rise, and studies showed that when it passed fourteen days a marked increase occurred in the demand for tests. But the basic factor in the elaboration of equipment and service was the stabilization of the rear areas during 1952. Here troops mainly were located in a few major concentrations around the urban areas and the ports. Disease and

⁵⁰EUSAK, Report of ETMD, October 1951, p. 8, file 350.05 (EUSAK) 1951, HRB.

nonbattle injuries dominated the admission rolls, especially during quiet periods on the front. The evacuation hospitals also provided outpatient clinics and diagnostic and consultant services. When battle casualties seemed likely to increase, medical authorities attempted to "clean out" the lightly injured, only to find that few qualified for the term. Though complex equipment, such as electrocardiographs and audiometers, had to be obtained by special authorization from Japan or the zone of interior, the hospitals were caring for substantial numbers of patients with fairly serious nonbattle conditions. As support troops grew in number, and the fighting along the line remained sporadic, the proportion of such patients held by the evacuation hospitals could only grow.⁵¹

With the creation of the KCOMZ, the 21st, 25th, and 171st Evacuation Hospitals plus the Swedish Red Cross Hospital were transferred to the new command. The remaining step was evident, and in early 1953 the KCOMZ evacuation hospitals again were reorganized and redesignated as station hospitals, with the added personnel, equipment, and bed strength of such installations. The history of the evacuation hospitals in many ways symbolized the transformation of the rear areas and, indeed, of the war itself.

From the earliest days of the Korean fighting, hospital ships of the British and American navies—later supplemented by another from Denmark—served first as seaborne ambulances and later as mobile hospitals. The original mission of such ships was to transport patients, giving care en route. However, Korean conditions made them far more valuable as floating hospitals. Ships loaded patients either by winching up litters directly from the docks, by lifting them from lighters at sea, or from helicopters landing on their decks. The first and third methods were by far the best, and the advent of the medevac helicopter meant that a hospital ship anchored off a port could receive patients with as little difficulty as one tied up to a pier. In evacuating to Japan, on the other hand, movement by air was preferable because of the delay, possible danger, and need for several transfers that a sea voyage imposed on the wounded. Evacuation by ship was rare after mid-1951. As a British surgeon had noted in the early days of the war, "One movement only is the ideal [for a wounded man]: direct from the field to a base hospital where he is able to remain for several weeks without interruption and . . . the sooner this movement from the time of injury takes place the better."⁵²

The result was what Rear Adm. Lamont Pugh called the "unique decision to leave the hospital ships in the Korean ports for considerable lengths of time." The ships became a new kind of mobile hospital in Korea, for all moved from place to place: sometimes supporting the Inchon invasion (as the USS *Consolation* did), or doing service in Japan for a while, or aiding the Hungnam evacuation, or simply shifting about the Korean coast as needed. Up to the end of September 1952 admissions to the three U.S. Navy hospital ships totaled some 40,662, about 35 percent battle casualties and the rest nonbattle injuries. Addi-

⁵¹EUSAK, Annual Report of Medical Service Activities, 1952, annex IV, pp. 11–13; FEC, Annual Report of Medical Service Activities, 1951, pp. 129–30. Both in HRB.

⁵²H. J. Bennett, "'Maine' Chance," *Journal of the Royal Naval Medical Service* 37 (Winter 1951): 79.



CARING FOR CASUALTIES ON BOARD THE USS *Consolation*

tionally, a large number of outpatients were treated, possibly equal to the total cared for aboard ship, for a ship at its pier could conduct a clinic just as capably as a conventional hospital could. With the early service of the HMHS *Maine* and the later arrival of the Danish *Jutlandia*, five such ships in all provided an unusual and successful addition to rear area medical resources, and another example of military hospitals whose function Korean conditions had transformed.⁵³

Such were a few of the salient points in the evolution of the Korean rear areas as the war shifted from one of movement to one of static confrontation. The improvisations of 1950 yielded to a stable, complex system designed to support a war of low casualties in which victory was not sought and for which no end could be foreseen. The KCOMZ assumed the form and many of the functions of the advance section of a World War II communications zone, while Japan continued to serve in a manner reminiscent of the British Isles during the campaigns of the European theater. In Japan lay the largest, most complex hospitals, and from the Japanese airports Air Force planes carried the most severely injured to definitive care at home.

⁵³Lamont Pugh, "Mercy Is Their Mission," *Army Information Digest* 8 (August 1953): 58.

CHAPTER 9

Definitive Care

War, rotation, and the natural transience of military life combined to bring many changes to the Far East Command (FEC), its logistical arm, the JLCOM, and the elaborate system of general and station hospitals in Japan. New faces appeared in top jobs during 1951. In August General Hays, the JLCOM surgeon, was reassigned to the zone of interior to become deputy surgeon general. On 16 October General Hume, the controversial chief surgeon of the Far East Command, returned to the United States for retirement. Replacing him was Brig. Gen. William E. Shambora, a capable, domineering man who was at least as much soldier as doctor. A graduate of Georgetown University, Shambora had served as surgeon of the Army Ground Forces and the Ninth Army during World War II, and since then of the First and Second Armies and the United States Army Forces, Pacific. Despite this major change, and the departure of the medical consultant and the Supply and Fiscal Division chief, the Medical Section staff remained fairly stable through the year, in part because the deputy surgeon, Col. Richard H. Eckhardt, the executive officer, Col. Robert E. Selwyn, and most of the division chiefs and consultants continued in their posts. No upheaval like that in the Eighth Army staff occurred.¹

The biggest changes for American forces in Japan were at SCAP, triggered by the approaching peace treaty. General Sams departed for the zone of interior, and on 1 July his Public Health and Welfare Section was discontinued after a brief interim in which Col. Cecil S. Mollohan, Sams' Harvard-trained deputy, replaced his former chief. The section's records and most of its personnel now shifted to Far East Command's Medical Section. The change portended nothing less than SCAP's approaching dissolution. Until his own departure General Hume took over as chief surgeon of SCAP without relinquishing his FEC role. For the time being, a rump section in SCAP advised the supreme commander on civilian health programs in Korea and Japan, while laboring to speed the transfer of full responsibility for public health and welfare in Japan to civilian agencies.²

¹Surgeon's Circular Letter 6, no. 11, Medical Section, FEC, 1 Nov 51, pp. 221–22, file 461 (Circular Letters) FEC; JLCOM and FEC, Annual Reports of Medical Service Activities, 1951, p. 13 and pp. 4–13, respectively, files 319.1–2 (JLCOM) and (FEC) Far East–1951. All in HRB.

²FEC, Annual Report of Medical Service Activities, 1951, p. 148, HRB. See also Surgeon's Circular Letter 6, no. 6, Medical Section, FEC, 1 Jun 51, p. 121, file 461 (Circular Letters) FEC, HRB. The peace treaty was signed on 8 September 1951 and became effective on 28 April 1952.

The reshuffling continued—indeed intensified—as the peace treaty went into effect in the spring of 1952. SCAP was abolished at the end of April. The designation *General Headquarters* was dropped by the United Nations and Far East Commands. In October the long-moribund paper command called United States Army Forces, Far East (USAFFE), sprang to life as the major Army headquarters under the Far East Command in Japan. Concurrently, the Japan Logistical Command was abolished and its missions and functions transferred to USAFFE. The Far East Command's Medical Section also shifted to USAFFE, with General Shambora designated as chief surgeon of both commands. The mergers saved some thirty-three spaces—a matter of some importance as the Korean struggle steadily lost ground in the worldwide competition for personnel. The net result was a simplified structure focused on the military, which had abandoned its onetime proconsular role as ruler of Japan.³

Medical functions likewise changed with the signing of the Japanese peace treaty. Because the treaty and the accompanying administrative agreement between the United States and Japan failed to specify answers to a number of medical questions—there were no provisions for controlling health problems resulting from the movement of Americans to and from Japan, no provision for animal and plant quarantine, and no provision for reciprocal exchange of information on communicable diseases—the preventive medicine officer began negotiations on such issues with the Japanese government. The Japanese also took control of the railroads, compelling the military to coordinate the movement of hospital cars with them. With reduced numbers the headquarters medics had plenty to do. Having both policymaking and operational duties, the Medical Section directed work in USAFFE, supervised the medical activities of Army units in the United Nations Command, and managed the joint medical regulation of all patients in the Far East Command. The list was impressive and made the Medical Section all-powerful in controlling the movement of the wounded back from the Korean battlefields and their treatment in the Army hospitals of Japan.⁴

Evacuation: The First Leg

The stream of injured human bodies pouring out of Korea reached Japan either by air transport or by water. Evacuation, like the war itself, developed through several well-marked phases. Though aircraft played a role almost from the beginning—even in July 1950, C-47s and C-54s were carrying patients from the 8054th Evacuation Hospital in Pusan to the 118th Station Hospital in Fukuoka, Japan—they were at first far less important than ships in the number

³United Nations Command General Order no. 53, 10 Dec 52; Far East Command General Order no. 108, 23 Apr 52, and General Order no. 169, 10 Dec 52; United States Army Forces, Far East, General Order no. 2, 10 Oct 52, and General Order no. 46, 19 Dec 52. All in MMFB.

⁴USAFFE, Annual Report of Medical Service Activities, 1953, pp. 1–2, file 319.1–2 (USAFFE) Far East–1953, HRB; JLCOM and FEC and USAFFE, Annual Reports of Medical Service Activities, 1952, p. 19 and pp. 1–2, files 319.1–2 (JLCOM) and (FEC) Far East–1952, HRB; Far East Command General Order no. 123, 13 Oct 52, MMFB; FEC, Report of ETMD, September 1952, p. 7, file 350.05 (FEC) 1952, HRB.

of wounded they carried. The prime function of airplanes during the tumultuous early weeks of the war was emergency evacuation, often direct from division clearing stations, as the only alternative to abandoning wounded men to an advancing enemy. Once the casualties were in Japan, the medical regulating officer, Eighth Army (later Japan Logistical Command), determined their further movements. In theory, casualties who were expected to recover within twenty-one days should have been held in Korea. In practice, however, the tactical situation and the available bed space determined who was evacuated and when. Because the war was going badly and few beds were on hand, the stream of evacuees became a torrent.

Frantic haste was the norm. Almost anything that floated was pressed into service. At the outbreak of the fighting the Royal Navy's HMHS *Maine* was at Kobe supporting elements of the British fleet in the Far East. The fifth such ship to bear the name, the *Maine* for her Korean service was to become the only hospital ship in British history to win a naval battle honor. Immediately offered to the United Nations (U.N.) forces, she arrived on 14 July in Pusan—a "hot, parched, swirling dust-bowl"—to aid the evacuation of the wounded to Japan. For the next two months the small ship, a captured Italian liner never intended for such work, carried 1,849 casualties, almost all Americans, to Fukuoka, Osaka, and Yokohama. Overburdened, with only one air-conditioned ward and temperatures in the lower decks rising above 100°F, the *Maine* saved lives primarily through the untiring efforts of her small professional staff. Among her patients were some who should not have been aboard at all, including psychoneurotics whose symptoms miraculously disappeared as Korea dropped astern and men whose only malady was their broken eyeglasses or dental plates. Though typical of the early days of the war, such cases were far outweighed by patients with severe, often appalling wounds and by neuropsychiatric casualties whose derangement was only too real.⁵

In the sweltering wards of the *Maine*, in the troop carriers USNS *Sgt. George D. Keathley* and *Sgt. Andrew Miller*, in tossing LSTs, and by some accounts in Chinese junks, the wounded endured a tedious journey that mocked the frenzy in which it had begun. Much more fortunate were those taken aboard the USS *Consolation*, which reached Korea in August. Over 500 feet long and displacing 15,000 tons, the ship bore distinctive markings; the hull was painted white with a horizontal green stripe and red crosses blazoned the deck, funnel and helicopter pad. More important, it was spotlessly clean within, well-equipped and designed for its task, with the machinery separated from the ward areas and the operating room located at the ship's center where rolling was least. The *Consolation* was one of six such ships built on the East Coast during World War II and known collectively as the Haven class. Among her sister ships, the USS *Benevolence*, newly fitted for Korean service, sank in a fog-shrouded channel off San Francisco. But the namesake USS *Haven* served at Inchon during 1950, at Pusan in 1951, and returned for a second tour during 1952; the USS *Repose* saw

⁵Bennett, "'Maine' Chance," pp. 72–86 (quoted words from this source); John H. Plumridge, *Hospital Ships and Ambulance Trains* (London: Seeley, 1975), p. 71. In August, evacuation policy for Korea was increased to thirty days.

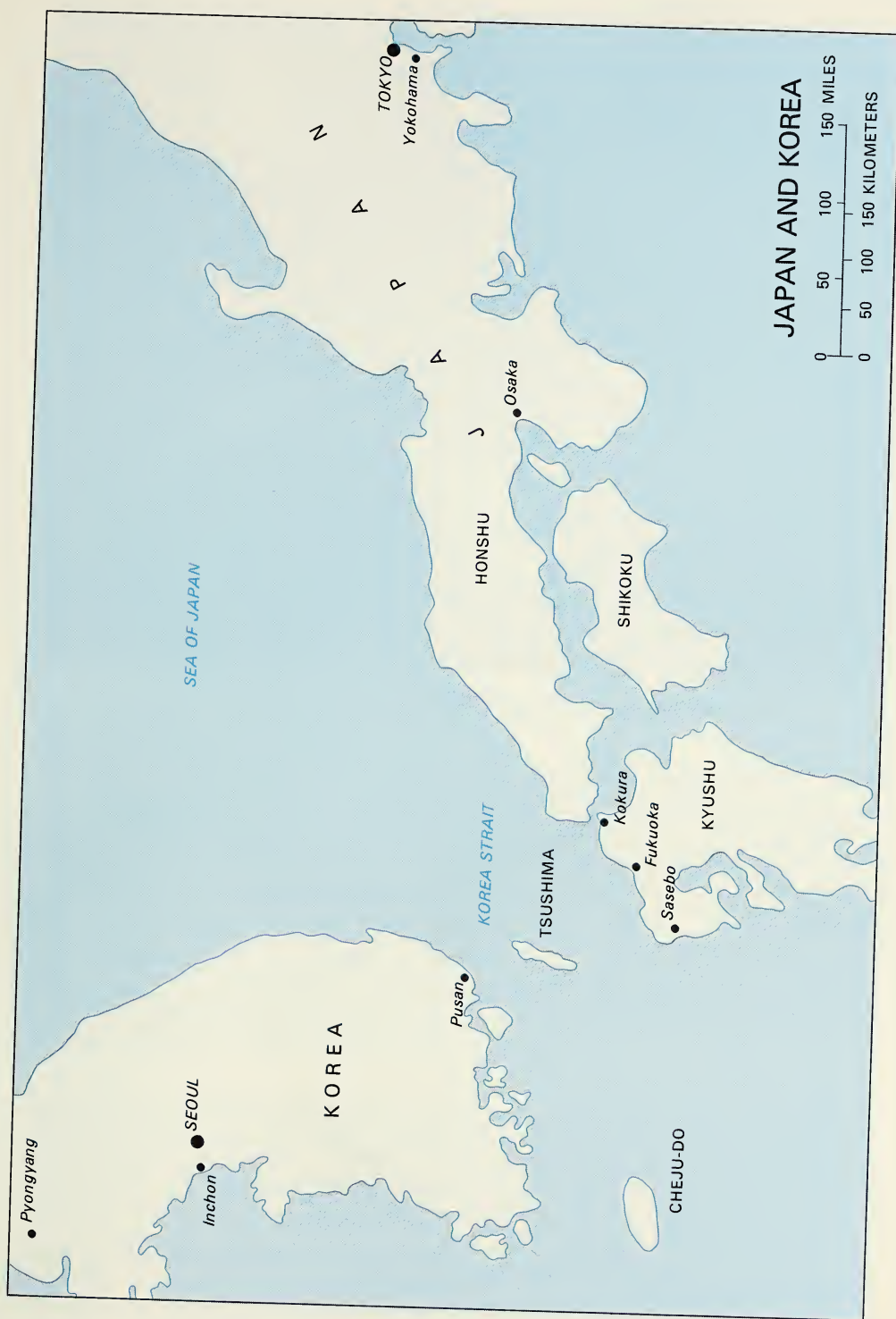


USS *Repose* AT INCHON

similar service. However, hospital ships rapidly turned from evacuation vehicles to floating hospitals in Korean waters, and their contribution to the movement of wounded was correspondingly limited.⁶

Critical to the early phase of evacuation was the month of September 1950. The invasion at Inchon, the enemy's Great Naktong Offensive, and the Eighth Army's breakout from the Pusan Perimeter swamped every type of transport. The number of casualties received from the combat zone reached its first peak, as did evacuations from Japan to the zone of interior. At the same time the character of the traffic changed. Air evacuations from Korea jumped almost twenty-fold, from 335 in August to 5,890 in September, while the number of sea evacuations fell from 4,459 to 2,171. Thereafter the air won out steadily, until by the end of 1951 water evacuation had almost ceased, except for a few patients who could not tolerate altitude. The overwhelming majority returned to

⁶Pugh, "Mercy Is Their Mission," pp. 53-59; extract from Ltr, Maj Gen Edgar Erskine Hume, Chief Surgeon, Medical Section, FEC, to Maj Gen Raymond W. Bliss, Surgeon General, DA, 11 Dec 50, HSF (Hume-1950), HRB; Weekend Letter no. 8, Col R. H. Eckhardt, Deputy Surgeon, Medical Section, FEC, to Maj Gen Raymond W. Bliss, Surgeon General, DA, 8 Nov 50, file 200 (Personnel Letters Between SGO and Medical Section, FEC), Box 3099 (Medical Section, FEC, General Records, 1950), RG 338, MMFB; extract from Msg, SECSTATE 183 to SCAP for USPOLAD, 2 Aug 50, HSF (SECSTATE-1950), HRB. See also E. B. Coyl, "Hospital Ships in Korea," *Military Surgeon* 112 (May 1953): 342-44.



MAP 6



AIR FORCE FLIGHT NURSE AIDING EVACUEE

Japan in the transport planes that droned at all hours into Air Force fields on the islands of Kyushu and Honshu (*see Map 6*).⁷

Initially, nearly all the evacuees landed on Kyushu, where ships tied up at the port of Kokura and planes landed at Itazuki Air Base, Fukuoka. Medical treatment followed at the 118th Station Hospital. The closeness to Korea of Japan's southernmost and westernmost large island made its use a necessity for many smaller planes. As a result, a 15-hour train ride to Osaka or a 27-hour journey to Tokyo followed for general hospital patients. In January 1951, however, a "tri-entry" system was introduced after enough C-54s had entered the airlift to bring the metropolitan areas of Honshu within flying range. Thereafter, casualties were divided on a 40-40-20 basis between Itazuki Air Base, Itami Air Base at

⁷Above paragraph is based on the following: Headquarters, JLCOM, Command Report, 1-31 Jan 51, Narrative Summary, pp. 75, 78, 80, file AYUT-8000 (JLCOM, Command Report w/Supporting Documents, Jan 51), Box 4840 (JLCOM, AYUT-8000, Narrative w/General Staff Sections, Jan 51), Entry 429, RG 407, MMFB; EUSAK, Annual Report of Medical Service Activities, 1950, pp. 7-8, file 319.1-2 (EUSAK) Far East-1950, HRB; JLCOM, Report of ETMD, September 1950, p. 1, file 350.05 (ETMD, Far East, JLCOM, 1950), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB; FEC, Report of ETMD, July 1950, p. 25, file 350.05 (FEC) 1950, HRB; JLCOM, Annual Report of Medical Service Activities, 1950, p. 9, file 319.1-2 (JLCOM) Far East-1950, HRB; EUSAK, Report of ETMD, August-September 1950, p. 6, file 350.05 (EUSAK) 1950, HRB; N. M. Kater, "Air Evacuation of Casualties in the Korean War," *Medical Journal of Australia* 2 (July 1953): 94.



UNLOADING AN AMBULANCE BUS AT TOKYO ARMY HOSPITAL

Osaka, and Tachikawa Air Base west of Tokyo, where the 376th Station Hospital received the wounded.⁸

An Air Force nurse described a round-trip flight from Japan to a forward airstrip in Korea during the winter of 1952. Outbound her plane carried mail. After off-loading in Korea it flew on over "the barren, rugged, desolate terrain now so familiar, once so frightening." The twisting dirt roads below were white with snow. At a forward airstrip MASH patients began to arrive while the nurse and a medical technician swept out the plane and unrolled the litter straps. As the casualties were carried aboard, their litter poles were buckled into the heavy web straps that ran from floor to ceiling, forming a rigid structure. The patients' injuries determined where they were put:

head injury up front, in the position third from the top, so you can give him oxygen or plasma easily; paraplegic opposite him, so that his drainage will function properly; a man whose left leg is amputated . . . on the floor, so there is enough room for the large round hoop holding the skin traction in place; . . . a man with hepatitis in the top position, since he won't need much nursing during the flight; and so on until you have all 30 patients on board.⁹

⁸Headquarters, JLCOM, Command Report, 1-31 Jan 51, Narrative Summary, p. 75, RG 407, MMFB. See also sources in previous footnote.

⁹This and the following paragraphs are based on Janice Albert, "Air Evacuation From Korea—A
(Continued)

Among the young patients, many of whom had never flown before, reassurance was as essential as clinical skill. The nurse calmed a frightened private, dressed a wounded man's colostomy, gave oxygen to a Turk with a penetrating chest wound, a narcotic to the amputee who was still not fully aware of the absence of his left leg—"a smile here, a gentle hand there, and soon the tension of the cabin is lessened, at least for the moment." And so to the airport in Japan, where ambulances were waiting.

Once arrived, patients at Tachikawa and Itami passed into the hands of medical holding detachments for a brief respite, examination, and triage. Those clearly destined for the zone of interior were sent to Osaka or Tokyo Army Hospitals for preparatory treatment, to make sure they could survive the long Military Air Transport Service (MATS) flight across the Pacific. For them, the next stop would be Midway Island. Those who remained in Japan were a mixed bag. Included were men too seriously wounded to remain in Korea but whose recovery was anticipated within the limit set by the current FEC evacuation policy—during much of the war, men who presumably would recover in more than 30 but less than 120 days—and others whom triage officers had judged to be in no condition to be sent to the zone of interior without stabilizing treatment. During the busiest months the men who stayed in Japan were simply those for whom beds happened to be available. Even the lightly wounded were shunted on across the Pacific, if the hospitals were full.

Within Japan a system of evacuation already existed at the time the war began, necessarily a somewhat complex one, for it served an island nation. Outlying units were reached by air, ambulance and rail; short trips were by ambulance. Emergency service was the province of the Far East Air Forces' Air Sea Rescue Squadron in Tokyo. When the outbreak of war stripped Japan of many of its ambulances, the Japan Logistical Command converted ordinary 32-passenger buses into 10-litter ambulances, modeling them after American vehicles already in the command. Because the hospital cars that the Eighth Army stationed throughout the islands were now too few, the Transportation Military Railway Service, at the command's behest, converted regular Japanese cars, which were rapidly pressed into service as the workmen finished them.¹⁰

The main influence on changing work loads and evacuation policies was the constantly shifting course of events on the Korean battlefields. As the North Korean Army collapsed in the fall of 1950, the influx of casualties plunged. On 22 September the JLCOM hospitals held 9,300 casualties, but on 25 October—when the first Chinese attack began—only 5,301. The FEC evacuation policy, after falling to 60 days, was changed back to 120 days during October. Then a new influx began—not only combat casualties but also the wave of cold injuries, the victims of General Winter. Between late November and late December 9,982 Army casualties were evacuated from Korea, of whom about 3,500 were wounded and the rest the victims of nonbattle injuries and disease, primarily frostbite. On 3 December the 120-day policy was again reduced to 60

(Continued)

Typical Flight," *Military Surgeon* 112 (April 1953): 256–59. All quotations from the article appear on p. 258.

¹⁰FEC, Report of ETMD, October 1950, p. 12, file 350.05 (FEC) 1950, JLCOM, Annual Report of Medical Service Activities, 1950, pp. 24–27. Both in HRB.

days. For all concerned, December was a busy month, the trains carrying some 8,900 hospital patients, 90 percent of them from the ports to the hospitals, only about 10 percent from the hospitals to duty.¹¹

By January 1951 the construction of new hospitals and greater specialization in those that existed began to change this thermometer-like response to the upheavals of the battlefield. On the nineteenth the 120-day policy was again reestablished, this time in the hope that any new surge could be accommodated without further change. Casualties airlifted from Korea now were divided into three groups: Patients with head, chest, and eye injuries went direct to the Tokyo area for specialized surgery; those with frostbite and hepatitis were flown to Osaka, where treatment centers for these ills had been established; and all other types were distributed according to available bed space throughout Japan. The tri-entry system went into effect at the same time, and by the end of the month the JLCOM surgeon judged it "about ninety percent effective." Patients received less handling and more rapid evacuation, the amount of interhospital traffic was less, and the load on hospital workers decreased. Even the spring Communist offensive did not compel any new change in the evacuation policy.¹²

By this time all the major elements of the evacuation system had emerged. Minor adjustments remained. During 1951 new hospitals opened in the Osaka area, making Itami Air Base for a time the preferred point of entry. Fluctuations in the number of patients continued during the spring and early summer, following the tide of battle. By early summer six hospitals were preparing patients for evacuation to the zone of interior, with the JLCOM medical regulating officer receiving their daily tallies and arranging transport from Itami Air Base and the MATS terminal at Tokyo's Haneda International Airport. Throughout the year the number of patients carried from Korea by water remained comparatively small, dropping to zero in September. Aggregates of battle and nonbattle casualties fell slowly from the highs of April until August, rising again with the autumn offensives. On average about six thousand patients a month arrived in Japan during the first half of the year.¹³

After the hard fighting of the autumn, falling casualties and expanded capacity relieved pressure on the evacuation system and the hospitals as well. In January 1952 only about two planeloads of patients a day arrived in Japan. Evacuation by water continued to decline. Unusual was the experience of some patients on the USS *Repose*, which docked in Yokosuka on its way to the zone of interior. Only thirty-nine of the forty-six wounded who were aboard required

¹¹Headquarters, JLCOM, Command Report, December 1950, Narrative Summary, p. 30, file AYUT-8000 (JLCOM, Command Report, Dec 50), Box 4624 (JLCOM, AYUT-8000, Narrative w/encls., Dec 50), Entry 429, RG 407, MMFB; JLCOM, Report of ETMD, December 1950, p. 20, file 350.05 (ETMD, Far East, JLCOM, 1950), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB; JLCOM, Annual Report of Medical Service Activities, 1950, p. 12, HRB.

¹²Medical Section, JLCOM, Command Report, 1-31 Jan 51, Supporting Documents (Annex 24), pp. 4-6, file AYUT-8000 (JLCOM, Staff Sections, Jan 51), Box 4842 (JLCOM, AYUT-8000, Staff Sections, J.A. to trans, Jan 51), Entry 429, RG 407, MMFB; JLCOM, Reports of ETMD, January 1951, p. 4, and February 1951, p. 3, file 350.05 (ETMD, Far East, JLCOM, 1951), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB; EUSAK, Report of ETMD, January 1951, p. 5, file 350.05 (EUSAK) 1951, HRB.

¹³EUSAK, Report of ETMD, September 1951, pp. 7-8, file 350.05 (EUSAK) 1951, HRB; JLCOM, Reports of ETMD, June 1951, app. 8, pt. 2, pp. 19-20, and September 1951, p. 48, file

(Continued)

treatment in the Japanese hospitals, and because the airlift was working well and no backlog of evacuees existed, the ship went on with its seven remaining patients in a condition approaching solitary splendor, voyagers on a 15,000-ton vessel where the staff outnumbered them many times over. In the beginning the patients had overwhelmed the system. By 1952, increasingly, the system was more than adequate for the patients.¹⁴

The Hospitals of Japan

Built for a peaceful occupation, the hospitals of Japan at first were swamped by the demands of war. Then, absorbing new personnel and constructing new facilities, they grew to maturity just about the time that the armistice talks caused the patient load to fall. Such an ironic capsule history, however, does not do justice to the system's achievements in meeting the emergency of 1950, to its continuing clinical excellence, or to its success in making the most of limited manpower resources even after the early tide of casualties had subsided. Throughout much of World War II the most persistent complaint of the medical profession against the military was that hospitals were overstaffed and doctors underused. Few such complaints surfaced during the early part of the Korean War, when with rare exceptions the Medical Service used improved transport and heightened professional skills to make much of little.

The frenzy of August and early September 1950, when there was enough of nothing except the wounded, tended to conceal the excellent foundation that existed in the prewar medical system. At the opening of the war thirteen hospitals were operating in Japan, with a normal capacity of about thirty-five hundred beds and an emergency capability of over fifty-three hundred. The auxiliary buildings to house the overflow patients, however, were not well suited to the purpose and were poorly equipped. Skilled foot-dragging by Eighth Army medical officers had prevented hasty execution of the surgeon general's orders to reduce the number of hospitals, and abundant stocks of World War II equipment were at hand. The true weakness of the FEC medical system lay in its lack of field units, whose formation stripped the hospitals of both professional and nonprofessional staff at the moment when the first waves of casualties were arriving from the front.¹⁵

The influx of new personnel from the zone of interior combined with frantic improvisation to bring about the first major expansion. Fortunately, the people of the Far East Command were by and large healthy before the war so that many vacant beds existed. Nevertheless, August 1950 saw the number of patients rise to the extreme limit of the hospitals' emergency strength. By the thirty-first the

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350.05 (ETMD, Far East, JLCOM, 1951), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB. See also other JLCOM, Reports of ETMD, for 1951.

¹⁴JLCOM, Report of ETMD, January 1952, pp. 27-28, file 350.05 (ETMD, Far East, JLCOM, 1952), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB.

¹⁵JLCOM, Annual Report of Medical Service Activities, 1950, p. 6, HRB.



TOKYO ARMY HOSPITAL

conversion of many camp, post, and station buildings into care units met the needs of about 6,700. Still the bed space was not enough, for the singular intensity of the Korean battlegrounds was to raise the average daily count of wounded past 8,000 in September and, after the autumn lull, to nearly 11,000 during one week of December. A civilian consultant reported:

I was amazed at the number of casualties [in Japan]. . . . There were 1400 alone in Tokyo. There were many psychiatric casualties and strangely enough they were boys who had been in Okinawa, Anzio, etc., but they couldn't take this battle. As a matter of fact, between 10% and 15% of the casualties are NP. All the boys felt they were terribly outnumbered. One patient remarked to me that 'we were out-numbered a thousand to one.'¹⁶

Visitors from the States found improvisation the rule. At a general hospital an ophthalmologist ran the orthopedic section during August. Doctors worked all night. Only one neurosurgeon in the Far East Command was fully qualified to operate on head and spine cases, and men whose injuries required treatment within twenty-four hours waited for days to be admitted to the operating room.

¹⁶Quoted words from SG Conference Notes, 16 Aug 50, Medical Collection, HRB. See also JLCOM, Annual Report of Medical Service Activities, 1950, p. 14a; Surgeon's Circular Letter 6, no. 3, Medical Section, FEC, 1 Mar 51, pp. 52-53, file 461 (Circular Letters) FEC. Both in HRB.

Centralizing the treatment of specific injuries in one or two hospitals and concentrating the specialists was an obvious way to meet the shortage of skilled personnel. Such juggling, however, could carry the command only so far. General Weible, the JLCOM commander, warned that both people and facilities were being used to the absolute limit and demanded more doctors and nurses, more money, and a construction program aimed at giving Japan the capacity to hold 24,000 patients. Meanwhile, evacuation to the zone of interior took the surplus: of 11,870 patients received during August, almost 1,300 were sent home.¹⁷

The October lull allowed General Hays and the hospital staffs to draw breath and assess the situation. Both the influx of casualties and the buildup of medical personnel for Korea had slowed. Evacuation to the zone of interior fell by 59 percent. Fewer new medical units were formed, and the 162 units already requested were canceled. Plans for an expanded hospital system, however, were held in abeyance, on a well-justified belief that the battlefield situation had not improved enough to warrant cancelation. Work continued to convert one camp to a hospital and to build one new facility. But clearly the pressure had abated; the number of occupied beds declined by 3,300 in mid-November and, for the first time since the coming of the war, the number of medical specialists was adequate. As 1950 drew to a close, shortages no longer plagued most clinical specialties.¹⁸

Specialization of the hospitals also had advanced. The two big installations at Tokyo and Osaka provided the most sophisticated care available in the Far East Command. All head and chest surgery cases went to the Tokyo Army Hospital. In November, as cold injuries proliferated, a center for the study and treatment of frostbite was set up at the Osaka Army Hospital, also the site of a major point for evacuation to the zone of interior. Wounded Britons received treatment at Osaka, but other U.N. casualties were sent to the Tokyo installation or the 361st Station Hospital because embassy personnel were available in the capital to act as interpreters. In addition to performing their usual duties, the station hospitals became more specialized: the 118th, as a receiving hospital and triage point; the 361st, as a neuropsychiatric center that also treated Japanese B encephalitis and as an evacuation hospital to the zone of interior; and the 35th, as a hepatitis center. The hospitals relied upon the 406th Medical General Laboratory for an array of technical services—tests, pathological studies, and research on viral and bacterial agents.

¹⁷Ltr, Maj Gen Walter L. Weible, Commanding General, JLCOM, to Commander in Chief, FEC, [20 Sep 50], sub: Hospitalization, tab 6, before document 1, Medical Section, JLCOM, Activities Report, 25 Aug to 30 Sep 50, file AYUT-8000, Annex 24 (Medical Section, JLCOM, 25 Aug-30 Sep 50), Box 4613 (JLCOM, AYUT-8000, Annexes 20-25, Aug-Sep 50), Entry 429, RG 407, MMFB; FEC, Report of ETMD, July 1950, p. 38, HRB; JLCOM, Report of ETMD, August 1950, p. 3, file 350.05 (ETMD, Far East, JLCOM, 1950), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB.

¹⁸Headquarters, JLCOM, Command Report, October 1950, Narrative Summary, pp. 28-31, file AYUT-8000 (JLCOM, Command Report, Oct 50), Box 4614 (JLCOM, AYUT-8000, Narrative w/encls. 1-9, Oct 50), Entry 54B, RG 407; JLCOM, Report of ETMD, October 1950, pp. 51-52, file 350.05 (ETMD, Far East, JLCOM, 1950), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112. Both in MMFB.



OSAKA ARMY HOSPITAL

With the onset of intense new fighting in late November, the drama of hospital expansion was replayed. Closed annexes reopened, plans were laid for lowering the evacuation policy when the JLCOM hospitals approached saturation, and the complex processes of renovating facilities—obtaining funds, seeking bids, and awarding contracts—resumed. In place of canceled requisitions the Japan Logistical Command now submitted new requests for three general hospitals. Meanwhile, the command pressed all its existing hospitals into service; in December, even the 161st Station Hospital, on the northernmost island of Hokkaido, took 73 evacuees from Korea. During that month one project was completed—rehabilitation of buildings in Kyoto intended as a convalescent center—and other contracts let. As daily admissions soared to 1,182, the evacuation policy fell to 60 days. Though bulging with more than 10,000 occupied beds, the hospitals by such expedients got past the second critical period of 1950. Intensified fighting in the spring and fall of 1951 and again in the autumn of 1952 brought new spurts in the influx of wounded, but after 1950 the most trying periods were past. The hospitals remained busy and some personnel shortages—notably in Army nurses and trained enlisted men—grew worse. The crisis, however, had ended.¹⁹

¹⁹Beginning in November, British Commonwealth troops were sent to the British Command of Forces General Hospital at Kure, Japan, as soon as they became transportable. On topics treated in
(Continued)

Throughout the war American and Japanese civilians were important in the JLCOM hospitals. As early as the end of 1950 a total of 653 Americans—including 18 doctors, 155 nurses, 308 clinical workers, and 102 attendants—were at work, relieving uniformed personnel for service elsewhere. Thousands of Japanese continued to work for the Medical Service in many capacities, as they had during the peaceful years of the Occupation. Japanese nurses served as nurse's aides, outnumbering the American civilian nurses in some hospitals; Osaka Army Hospital, for example, had 2 civilian nurses but 18 Japanese nurse's aides. U.N. nurses also appeared during 1950, 16 Thai nurses being among the first to serve in Japan.²⁰

During 1951 the buildup of medical units was steady. Three new general hospitals—the 279th, 382d, and 343d—arrived, as well as the 2d MASH. The battered 171st Evacuation and 64th Field Hospitals returned from Korea and were ordered to refit and prepare to reenter the battle zone. In the permanent plants renovation and new construction continued, both to expand existing hospitals and to provide buildings for the newly arrived general hospitals. New organizations and increased bed strength enabled the Far East Command to handle the casualties of the Communists' February counteroffensive without changing the 120-day policy. Similarly, the Japan Logistical Command reported that enemy attacks during May did not cause any appreciable increase in the patient census of the hospitals under its control. Indeed, orders received from Washington in late March led to a cutback in the command's medical complement and the inactivation of several hospitals and dispensaries. If one event had to be selected as marking the attainment by the hospital system of sufficient strength to handle the demands of the front, it might well be the completion on 15 March at Camp Drew of a plant intended for the 343d General Hospital. At this time 81 percent of admissions in Japan originated in Korea. But bed occupancy was declining, a sufficient number of beds were on hand to accommodate a moderate increase in the patient load, and the command wanted one hospital unit in reserve. Consequently, the 343d's equipment was packed up as a unit assembly and the outfit itself, in reserve status, served as a pool of replacements for others. The newly completed plant passed into the hands of the Air Force.²¹

(Continued)

these paragraphs, see JLCOM, Reports of ETMD, 1950–52, file 350.05, Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112, MMFB; JLCOM, Command Reports, 1950–52, files AYUT–8000, Boxes 4608–27, 4840–4900, 5592–5630 (JLCOM, AYUT–8000, Command Reports, 1950–52), Entry 429, RG 407, MMFB; Surgeon's Circular Letter 5, no. 12, Medical Section, FEC, p. 3, file 300.5 (Circular Letters) FEC, HRB; JLCOM, Annual Report of Medical Service Activities, 1950, p. 16; 406th Medical General Laboratory, Annual Reports of Medical Service Activities, Professional Sections (Annual Historical Reports), 1950–53, files 319.1–2 (406th Medical General Laboratory) Far East–1950, –1951, –1952, –1953, HRB.

²⁰JLCOM, Report of ETMD, December 1950, p. 22, RG 112, MMFB; Osaka Army Hospital, Annual Report of Medical Service Activities, 1950, p. 93, file 319.1–2 (Osaka Army Hospital) Far East–1950, HRB.

²¹Above paragraph is based on: FEC, Annual Report of Medical Service Activities, 1951, p. 89, HRB; JLCOM, Reports of ETMD, January 1951, pp. 3 and 6–7, February 1951, p. 3, March 1951, pp. 3–4, and May 1951, p. 1, file 350.05 (ETMD, Far East, JLCOM, 1951), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112, MMFB; Medical Section, JLCOM, Command Report, 1–31 Jan 51, Supporting Documents (Annex 24), pp. 7–8, RG 407, MMFB; Chart, "Proposed Hospital

In consequence, patient losses—usually by return to duty—about balanced gains until December, when beds were emptying faster than new casualties could fill them. Some organizational changes occurred. The Air Force took control of facilities at its headquarters command and at two air bases. Army hospitals endured another round of redesignation, this time in accordance with a scheme that gave each an army unit number. For example, the 118th Station Hospital became the United States Army Hospital, 8162d Army Unit; the 35th Station Hospital, the United States Army Hospital, 8164th Army Unit; and so on. Specialization also increased; in particular, the psychiatric service reached maturity. Psychiatric centers functioned at the 361st Station Hospital, at the Tokyo and Osaka Army Hospitals, and at the 141st General Hospital. By the end of the year the centers had closed-ward facilities and sophisticated equipment, including electroencephalograph machines. Neuropsychiatric casualties were triaged at the airports like other patients according to the seriousness of their condition and sent on to the proper facility.²²

The early months of 1952 saw a stalemated tactical situation in Korea. Despite inadequate cold weather discipline along the front, troops suffered far less than in the winter past, for the weather was relatively mild. In turn, the role of the hospitals in Japan diminished. Through 1952 hospital staffs and facilities were maintained at the highest authorized levels; however, the tempo of the fighting was such that this medical potential did not have to be tapped. Occasional flare-ups on the front, bringing a flurry of activity to one or more hospitals, subsided almost as soon as they began. In many ways the hospital system might be compared to an athlete who reaches the peak of training and capacity only to be told that the game has been called off. In November 1951 some 97 percent of operating—that is, fully staffed and equipped—beds were occupied. Weekly thereafter the total fell, hitting 50 percent by the end of January and 38 percent by May. What the JLCOM surgeon called “a milestone” came on 20 April when, for the first time since early August 1950, the number of occupied beds dropped below the four thousand mark.²³

Hospital services responded to the tide of battle in varied ways. The surgical service reacted quickly to events in Korea, notably, during 1952, to the fighting for Old Baldy. Then the demand on a few hospitals was very great, even though no general inundation of wounded occurred. The work of the medical service varied with the seasons, heavy during the first three months of the year but fairly constant and predictable thereafter. Personnel problems continued, with

Reorganization Scheme To Meet Required Over-All Spaces Allotted,” document 11, Medical Section, JLCOM, Command Report, 1–30 Apr 51, Supporting Documents, file AYUT–8000 (JLCOM, Staff Sections, Apr 51), Box 4857 (JLCOM, AYUT–8000, Staff Sections, IG to Ord, Apr 51), Entry 429, RG 407, MMFB; JLCOM, Annual Report of Medical Service Activities, 1951, pp. 7, 23, 54, HRB. The 343d General Hospital was not put into operation as a unit until September, and then against the Japan Logistical Command’s wishes.

²²Surgeon’s Circular Letter 6, no. 11, Medical Section, FEC, 1 Nov 51, p. 228, HRB; FEC and JLCOM, Annual Reports of Medical Service Activities, 1951, pp. 29, 34–35 and pp. 8, 18, respectively, HRB; JLCOM, Report of ETMD, September 1951, p. 46, RG 112, MMFB. Technically, the station hospitals were inactivated and the army units organized to replace them.

²³JLCOM, Reports of ETMD, January 1952, p. 24, and April 1952, p. 13, file 350.05 (ETMD, Far East, JLCOM, 1952), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112, MMFB. Quoted words from April report, p. 2.

major shortages among the nurses resulting in demands for better quarters and treatment and for training of enlisted personnel to perform basic nursing tasks. Because of a continuous shortfall of nurse anesthetists, specialized courses were opened in the general hospitals. Meanwhile, civilian consultants continued to pass through, conducting teaching rounds for the medical officers and giving both formal and informal instruction in their specialties. Through the operations of the draft the number of doctors, including formerly scarce specialists like orthopedists, was adequate in relation to the number of patients.²⁴

Improvements in the treatment of burn victims, of neuropsychiatric casualties, and of hemorrhagic fever cases, the very high quality of surgery, and continued functioning of the blood program all contributed to the record of the hospitals in saving lives and returning men to duty. Hospital deaths during most of 1952 ran at only 1.1 per 1,000 troops per annum throughout the Far East Command. A seven-month study indicated that 89 percent of those returned to duty by the JLCOM hospitals were fit for general military service. From its roots in the impossible conditions of August 1950 the hospitals of Japan had progressed to a happy situation in which almost all factors conspired to aid both the staffs and the men they treated. The numbers told their own story, in work where the bottom line was life.²⁵

On the Wards

A hospital was a military unit, a physical plant, and a shifting yet oddly stable society of the sick and the well. Physically, the Army hospitals of Japan came in many shapes and sizes. Some were complexes, medical hamlets in effect, attached to bases or centered in large cities. The Osaka Army Hospital was a former Japanese Red Cross installation located in the metropolis of southern Honshu. Covering more than 14 acres, its compound held about fifteen structures. The main plant consisted of three connected five-story buildings, but behind its tree-shaded wall, the tall stacks of the power plant and the low peaked roofs of satellite buildings also could be seen. The Tokyo Army Hospital stood near the center of the capital, with an annex located about a mile away. A seven-story concrete building constructed by Christian missionaries, the main hospital was marked by a tower topped by a cross. On the Sumida River a few miles from central Tokyo stood the 361st Station Hospital, a prewar Japanese establishment taken over by the Army. The 155th Station Hospital in downtown Yokohama was a former department store, the Matsuya, converted into wards and clinics; it was a handsome brick and stone structure with some seventy satellite buildings of much less prepossessing design. The 118th Station

²⁴FEC and USAFFE, Annual Report of Medical Service Activities, 1952, pp. 35–36, 47, 63; FEC, Report of ETMD, July 1952, file 350.05 (FEC) 1952. Both in HRB. Doctors were 21 percent below authorization and nurses 45 percent below. In December 1952 nurse authorizations were reduced to the number actually present in the command.

²⁵FEC, Reports of ETMD, May 1952, pp. 8, 10, and July 1952, p. 3, file 350.05 (FEC) 1952, HRB.

Hospital in Fukuoka, the main entry and triage point in the early days of the war, was again the typical solid reinforced-concrete structure most appropriate to earthquake-prone Japan. Seventy-one buildings surrounded the main hospital. Finally, the 376th Station Hospital at an air base west of Tokyo represented the pavillion-type hospital, with low wards in separate buildings connected by covered walkways. By and large, the main hospital buildings were durable structures, sometimes attractive but more often grimly functional, many with the look of industrial plants.²⁶

The events of mid-1950 meant a drastic upheaval for the Tokyo and Osaka Army Hospitals and for many who worked there. Before the fighting started, life revolved around the usual concerns of work, quarters, and recreation. To some extent self-contained communities, both hospitals provided movies, clubs, and sports teams for their staffs. Both published newsletters, *The Host* at Osaka and *The Tower* at Tokyo.²⁷

Such routine concerns hardly prepared the hospital staffs for the events that followed 25 June. Stripped of their professional—especially surgical—personnel during July, both the Tokyo and Osaka Army Hospitals began at about the same time to receive the first Korean casualties. Abandoning elective procedures and ousting some dependents, they struggled to accommodate the influx. For a short time, Tokyo had only eleven doctors for its thousand-bed facility. At Osaka, proportions of 1 medical officer to 90–110 seriously injured patients were not unusual.²⁸

For the new patients, beds were set up in hallways, lobbies, and recreation rooms. To control patient loads, those who required only minor care began to be transferred to convalescent centers—for Tokyo, the 128th Station Hospital and Camp King. Designated to receive U.N. casualties, Tokyo treated over 800 during 1950, including Turks, Frenchmen, Britons, Indians, Canadians, Australians, Swedes, Thais, Dutch, Filipinos, and South Koreans. As the number of battle casualties soared during August, the hospital set up three large ward tents just outside the walls as an admission and disposition section. Here hospital personnel, Red Cross workers, laboratory technicians, and volunteers carried out initial examinations, prepared paperwork, and sent the patients on to proper treatment inside. With the coming of winter a hastily constructed temporary building replaced the tents that had served so well in warm weather.

Treatment at the Tokyo Army Hospital emphasized conservative handling of two very common afflictions, burns and frostbite. Abandoning the traditional treatment of burns with vaseline gauze dressings, the surgical service adopted an Army-pioneered method in which, after initial debridement under antiseptic conditions, the wound was simply exposed to the air while the patient received antibiotics to prevent infection. Over the burn body fluids formed a natural

²⁶See photos in annex to JLCOM, Annual Report of Medical Service Activities, 1950, HRB. See also reports of cited hospitals, same location.

²⁷See, for example, Osaka Army Hospital, Annual Report of Medical Service Activities, 1950, pp. 24–30, HRB.

²⁸Chart 1, "Strength, Gains and Losses: Japanese and Foreign National Personnel, 1 Jan 51 to 31 Dec 51," follows p. 22 of *ibid.*; Tokyo Army Hospital, Annual Report of Medical Service Activities, 1950, p. 64, file 319.1–2 (Tokyo Army Hospital) Far East–1950, HRB.

crust that was dry, free of odor, and relatively painless. Where the skin was only partly destroyed, the crust after a few weeks separated naturally, revealing normal but slightly reddened healing beneath; where deep burning had occurred, surgeons removed the crust about the twentieth day and grafted new skin over the site. In the opposite case—cold injury—the hospital favored gentle cleansing and bed rest, exposing the injured extremities to the air, and delaying amputations as long as possible. Toes that had become black and appeared gangrenous would often spontaneously shed the dead superficial layer to reveal a “pink but complete and functional digit underneath.” By avoiding amputations, except where necessary, and by emphasizing supportive treatment the hospital not only obtained excellent clinical results but also sharply reduced demands upon the time of overworked doctors and nurses.²⁹

Dental care in the Japanese hospitals was heavily dependent upon civilian assistance. Typical was the Osaka Army Hospital. Here, as in the field, dental officers sometimes were called upon to assist in busy operating rooms, especially during 1950. At other times a staff of five American and six Japanese dentists worked at a dozen chairs, assisted by five enlisted and seven Japanese technicians. All had the benefit during 1950 of an amenity that only came to the field later, a dental X-ray machine. With a large clientele of hospital patients and personnel, plus an outpatient service for units in the area, the clinic boasted a “most complete” service. Its laboratory not only made dental plates but also served other needs as well, making splints for fracture cases and turning out plastic eyes.³⁰

Like other parts of the Japan Logistical Command, the dental service spent the last half of 1950 frantically shuffling officers in an attempt to meet the needs of the units in Korea while maintaining service in the Japanese hospitals. The field came first, and by December the 124 dentists available in June had shrunk to 70. In this setting the policy of hiring Japanese dentists and technicians, begun in 1949, proved its worth fully. Graduates of recognized colleges in Japan entered the Army hospitals as operators, technicians, oral hygienists, chair assistants, dental laboratory mechanics, and X-ray technicians. By the time the war began, many of these skilled people already had eighteen months of experience and were well versed in Army methods.

With their mixed military and civilian staff the dental facilities of the command attempted to take on the duties of a communications zone. Troops passing through on their way to Korea were examined at the Medical Replacement Training Center, and prostheses made on the spot, so that soldiers arriving at the front would have as few dental problems as possible. For troops stationed in Japan, divisional dentists provided all care except prostheses. Logistical units were in constant turmoil with new people arriving and those in Japan moving out. Dental surveys were difficult, not only for this reason but also because new recruits arrived from the zone of interior with mouths that seemed to have

²⁹Edwin J. Pulaski et al., “Evaluation of the Exposure Method in the Treatment of Burns,” *Surgical Forum: Proceedings of the 37th Clinical Congress of the American College of Surgeons* (San Francisco, 1951), pp. 518–23.

³⁰Osaka Army Hospital, Annual Report of Medical Service Activities, 1950, p. 104, HRB.

received no attention whatever. As replacements moved toward the front, wounded men arrived back in the hospitals with injuries of the mouth and jaws, many, because of air evacuation, only a few hours old.³¹

One such case was, ironically, that of a 28-year-old dental officer shot in the mouth during an ambush in North Korea on 8 December 1950. His lower jaw was broken, his upper damaged, his lip, tongue, and right cheek badly torn. A field hospital sutured the wounds—MASHs at this time had no assigned dentists or oral surgeons—and the patient was evacuated to a station hospital in Japan. There surgeons removed fourteen broken teeth and noted that the wounds had become infected. Eight days after being shot in the field the patient was in the Tokyo Army Hospital. Here an oral surgeon and the surgical consultant worked together on the case. Whisked away almost at once to the operating room, the patient underwent a complex stabilizing treatment. The surgeons debrided his tongue, drew the healthy tissue together and sutured it. Exploring a suppurating wound in his right cheek, they found the cause of infection—the embedded crown of a smashed molar. The lip was debrided and closed. The loss of so many lower teeth, however, caused it to turn inward. Technicians had shaped an acrylic splint to replace the shattered dental arch and immobilize the broken lower jaw. Its insertion also filled out the lower part of his face, leaving him entirely presentable, though clearly a man who had undergone an unpleasant experience.

Two weeks after the operation all wounds appeared to be healing. The patient, however, was a long way from the end of his journey, in any sense. The destruction of the lower jaw was too extensive to be met by a denture, and both the complexity of the reconstructive work to be done and the length of convalescence that would be required pointed to the hospitals of the zone of interior. On 30 December the young dentist left for home.³²

Surgeons in Japan, like their opposite numbers in the field, encountered conditions for which their training had not prepared them. As MASH surgeons had already noted, the Korean, Turkish, and Filipino soldiers were full of parasites, and the long roundworms called ascarides proved as mobile as ever, occasionally working their way through suture lines in the intestines and migrating through abdominal incisions, spreading infection and creating fistulas. Self-mutilation was a problem not limited by nationality. A large number of self-inflicted gunshot wounds of the left hand and left foot showed up during the months of retreat, often destroying bones, tendons, and soft tissue. Patients stoutly maintained that the North Koreans or Chinese had shot them. The surgical service reported caustically that “the consistency in location and scope of these wounds is a tribute to the marksmanship and perversity of the enemy.”³³

Crowding the wards were not only medics and wounded but also a stream of more or less distinguished visitors. The civilian consultants who came to lecture and conduct ward rounds proved a mixed bag: Two were praised for inspiring

³¹JLCOM, Annual Report of Medical Service Activities, 1950, pp. 79–83, HRB.

³²Tokyo Army Hospital, Annual Report of Medical Service Activities, 1950, pp. 54–55, HRB.

³³Ibid., pp. 17–19, 47, 52, HRB. Quoted words on p. 17 of this source.



JOE DIMAGGIO (*right*) AND LEFTY O'DOUL (*left*) touring ward at Tokyo Army Hospital

work and teaching, while the others, in the opinion of the hospital's commander, "might very well have remained in the United States." Entertainers who toured the hospital wards ranged from local talent, such as Japanese Geishas, dancing groups, children's orchestras, judo acts, men's choral groups, and carolers, to world-class stars like Bob Hope and Al Jolson, Joe DiMaggio and Lefty O'Doul. Japanese civilians gave flowers, souvenirs, dolls, and books, and Army and civilian clubs contributed a variety of personal items, from matches to electric razors, to ease the time U.N. troops spent in the hospital.³⁴

At Osaka, wartime upheavals were even more pronounced than at Tokyo. While Tokyo saw thirteen changes of command during 1950, Osaka at the end of the year was left with only one of the officers who had been there at the beginning. Amid this chaos, treatment of the wounded somehow proceeded. As at Tokyo, the largest single contributor to the vastly increased volume of surgery consisted in the debridement and secondary closure of shell fragment wounds. Though most were treated in Korea, during the Chinese attack some men with abdominal wounds were flown directly from the battlefield without preliminary surgery. Perforating wounds of the intestines were common, and both hospitals labored to impress upon field surgeons the importance of the proximal colostomy.

³⁴Ibid., pp. 40, 58, 79, HRB.



FRACTURE WARD AT TOKYO ARMY HOSPITAL

my—that is, creating an artificial anus close to the site of an intestinal wound to divert the fecal stream and prevent infection.

Orthopedic injuries also were common. In prewar days, when more time was available, compound fractures were treated in Japan. Except in rare cases, few such open reductions and internal fixations were performed once the fighting had begun. Orthopedic surgeons now were content to immobilize compound fractures and evacuate the victims as early as possible for definitive treatment in the zone of interior. In the treatment of frostbite cases Osaka—after November designated the center for such work in Japan—apparently was quicker to use the knife than Tokyo. In its operating rooms a “master table” was set up, with instruments and drapes constantly resupplied. Instead of laying out the special requirements of each individual operation, the scrub nurse, using sterile forceps, drew from the master table whatever was needed for the operation next in line.

Cited at Osaka during 1950 was an ever-increasing load of cases with gas gangrene. An extremely serious infection, clostridial myositis gained its common name from the bubbles of gas formed in the wound by bacterial action. Anaerobic organisms typically infected deep wounds in large muscles (the thighs and buttocks were particularly susceptible) that had only small openings to drain and admit air. The danger of spreading the infection was so acute that in Korea such cases were sometimes operated on in the hallways of the MASH to avoid contaminating the operating room. At Osaka the busy operating rooms,

impossible to vacate after each gas gangrene case, were scrubbed down to prevent cross-infection. A typical victim died at Osaka on 2 December 1950—a sergeant wounded in both legs by shrapnel (such fragments always caused more septic wounds than small arms ammunition). Gas gangrene developed in the left leg, and the invasion of the bloodstream by bacterial toxins brought death.

Most unusual was a single case of tetanus, a wound infection from which immunized U.N. soldiers were ordinarily free. Wound cultures showed the presence of anaerobes and the patient had trouble opening his mouth. A wounded hand was amputated; then, as the toxin took hold, treatment for tetanus began. Surgeons performed a tracheotomy and paralyzed the victim with curare to prevent the violent, sometimes spinebreaking convulsions typical of the infection. Kept alive in a respirator, and injected with massive doses of antitoxin and antibiotics, the patient was fed by tube through two weeks of round-the-clock nursing, frequent spasms, and occasional moderately severe convulsions. Suffocation, despite the respirator, appeared to threaten at least twice. After three weeks the patient began to take solid food again, though his ordeal had left him acutely depressed and at times disoriented. Held in a closed ward under observation, he was dispatched to the zone of interior, lucky to be alive after an experience that might make any soldier glad to take his shots.

Many of those who did not go to the United States for their treatment received physical therapy in Japan. For men who had suffered a variety of injuries—burns, wounds with impairment of the peripheral nerves, neuropsychiatric cases with psychosomatic symptoms—therapy was an essential part of treatment. When any part of the body was immobilized for a long time, or when moving it caused immediate pain, the patient compensated as far as possible by using other muscles, forgetting the use of the injured limb or muscles. Therapists traced out the tendon or muscle on his body, explained its proper function, and assigned exercises that gradually restored normal use. Wartime brought physical therapists many patients—men with chest injuries who must, in a measure, relearn the art of breathing; frostbite victims whose exercises were designed to restore circulation and prevent joints from becoming rigid; burn patients needing hydrotherapy to prevent contractures and restore function to damaged extremities; plastic surgery cases; and amputees who must learn a new and initially difficult means of getting about and performing ordinary activities.

Because the desperately ill commanded all available bed space, efforts were under way at Osaka, as well as at Tokyo, to find additional facilities for the convalescing who still required medical attention. Osaka had operated an enlisted medical technicians school during early 1950; in August this was redesignated Annex 1 and opened as a hospital with 220 beds, which quickly doubled. Without elevators and short on latrines this former high school, a U-shaped four-story building of modern but undistinguished design, was a fine example of a structure that should not have been a hospital. Soon a still odder building had to be pressed into use: the Osaka Stock Exchange, which had seven floors and two elevators, both too small to hold a litter. At the end of November this building became the frostbite center and remained as such until the end of the



TURNING A PARAPLEGIC IN A STRYKER FRAME

year. As Annex 2 it became a busy hospital in its own right under the command of Lt. Col. Kenneth D. Orr, who was later to coauthor many of the basic studies in cold injury prevention and treatment that came out of the Korean War. Incomparably the largest single cause of admissions to the medical service at Osaka, frostbite—often complicated by other wounds or by disease—became its most distinctive concern. In all, over two thousand cases of cold injury were admitted to the hospital during 1950.³⁵

In October 1951 Osaka underwent another major increase in work load when the JLCOM surgeon designated it, along with Tokyo's 361st Station Hospital, a center for epidemic hemorrhagic fever. At the end of the year over three hundred cases of the illness were concentrated at Osaka for study and treatment. The requirements for careful nursing and a prolonged convalescence burdened its facilities to such an extent that many enlisted patients were shifted elsewhere for care after the acute period of the disease had passed. Seven hemorrhagic fever victims died. In 1952, with the establishment of the 8228th MASH in Korea as the center for handling and studying the disease, fewer cases reached Japan. Stabilization of the front had enabled another rear-area function to shift forward to the Eighth Army area.

³⁵Above paragraphs are based on Osaka Army Hospital, Annual Report of Medical Service Activities, 1950, pp. 47, 57–60, 67–68, 71–72, 79–80, 86, 89, HRB.

Study and treatment of cold injury, however, continued on a seasonal basis in Japan as well. In May 1951 the cold injury section closed and its staff moved to Fort Knox, Kentucky, taking with them a number of frostbite patients for further study. Here the basic research was done that made the Korean War a decisive event in medical understanding of the phenomenon. Contact with the Far East continued, for Korea remained overwhelmingly the place where the patients were. At the end of November 1951 the cold injury section was reestablished in Annex 2, and an interservice team of Army, Navy, Air Force and Public Health Service medical officers carried on the work under the Department of Defense. During the ensuing six months 370 cases were admitted, all evacuees from Korea. When the section closed for a second time in April 1952, the Army contingent returned to Fort Knox as the Japan division of the Army Medical Research Laboratory.

By and large, work at Osaka had become so standardized as to lack major surprises. Statistical quirks appeared as the influx of cold injuries during January 1951, and hemorrhagic fever cases in October caused the ratio of surgical cases to the total patient census to sink to the lowest point of the year. Surgery continued to be primarily concerned with Korean evacuees; the most serious cases—patients with colostomies, with chronic empyema (accumulation of pus) in the chest, with large torn wounds of the muscles, with nerve injuries, or with extensive burns—were returned to the zone of interior as soon as they were transportable. This practice was in accord with the evacuation policy, for such injuries probably would require more than 120 days of treatment before return to full duty status. Unlike the first year, wounds were clean and well debrided and wound infections few.

Overall, the general drift in the hospital was toward reduced strength, though subject always to the vagaries of the war. The seasonal closing of the cold injury section always brought with it a fall in bed strength. During mid-1952 the decline in battlefield action enabled the surgical staff to clear beds from corridors, alcoves and dayrooms, breaking them down and returning them to storage. In October some had to be reassembled as casualties began to increase again. With the signing of the Japanese peace treaty, several of the buildings previously used as convalescent annexes had to be emptied and turned back to civilian owners.³⁶

The larger station hospitals, especially those in major cities, approximated the army hospitals and general hospitals in size and in the variety and complexity of the cases they treated. During 1950 the 361st Station Hospital on the Sumida River in Tokyo underwent the usual experiences, losing much of its staff to field units while its patient load rapidly increased from a normal 100–120 to over 500. As South Korean, Turkish, Filipino, and other U.N. soldiers appeared on the wards, where they “behaved in a most comradely fashion,”³⁷ baffled medics labored to take histories in many tongues.

³⁶Above paragraphs are based on *ibid.*, 1951, pp. 40–41, 44, 67, and 1952, pp. 8–9, 37, and annex XI, pp. 5–6, 47–48, files 319.1–2 (Osaka Army Hospital) Far East–1951 and –1952, HRB.

³⁷361st Station Hospital, Annual Report of Medical Service Activities, 1950, p. 10, file 319.1–2 (361st Station Hospital) Far East–1950, HRB.

In 1951 the hospital continued to provide a complex array of services, including station hospital and outpatient care for its immediate area; specialized care for infectious diseases of the central nervous system, primarily encephalitis and polio; and centralized care for dermatologic, neuropsychiatric, and hemorrhagic fever cases. The main building was surrounded by the nurses quarters, a four-story annex housed in a onetime high school, and by utility buildings, gymnasium, and theater. Enclosed runways connected the nurses quarters to the main building. A prison ward provided care not only for jailed Americans but also for Japanese war criminals from the Sugamo Prison; the latter were said to receive "the same courteous and capable treatment" as the others. Contemporary photographs show a clean, solid, well-equipped hospital of conventional style, with two-bed cubicles in the long enlisted wards, and floors of polished tile in the surgery, therapy, and mess areas. In the occupational therapy section were hand looms, painting equipment, and other customary devices for restoring manual skills while passing time.

The 361st Station Hospital (renamed in 1951 the United States Army Hospital, 8167th Army Unit) was the facility at which many an incoming psychiatrist began his service in the Far East, learning the ropes before being sent to forward posts. After rising sharply with the war neuropsychiatric casualties showed the usual pattern of decline, falling over 44 percent from 1951 to 1952. Psychiatrists attributed the drop not only to lower combat activity but also to the increased facilities in Korea and the general shift to outpatient treatment of the less seriously disturbed in both Korea and Japan. Psychotic disorders, on the other hand, tended to occur with small regard to environmental conditions. The rising proportion of psychotics among the total number of neuropsychiatric casualties indicated, therefore, that the combat fatigue cases were retained in Korea. By 1952 the neuropsychiatric service reported that significantly fewer nonpsychotics were evacuated to the zone of interior, which more and more was the prerogative of the seriously and perhaps permanently ill.³⁸

The 35th Station Hospital in Kyoto was apparently a fairly sleepy installation of three hundred beds when the war began. Within a few months bed strength rose to two thousand and the actual patient census to 1,950. In August the FEC medical consultant made the hospital a hepatitis center, to provide centralized treatment for one of Korea's most common endemic ills. By the end of December the hospital and one of its new annexes held 552 hepatitis patients. Compared to battle casualties or hemorrhagic fever victims, such cases required little active nursing. Listless and sometimes without appetite, they needed to be warehoused and monitored while their sometimes dangerous disease, its cause as yet unknown, ran its course.³⁹

In 1951, however, a hepatitis center was set up at Kyoto Army Hospital, and the hepatitis study team, organized during the spring in the zone of interior, arrived in September for a year of work. Systematic study and follow-up of 461

³⁸United States Army Hospital, 8167th Army Unit, Annual Report of Medical Service Activities, 1951, pp. 1-2, 6-7, 17, 31, file 319.1-2 (U.S. Army Hospital, 8167th Army Unit) Far East-1951, HRB.

³⁹35th Station Hospital, Annual Report of Medical Service Activities, 1950, p. 5, file 319.1-2 (35th Station Hospital) Far East-1950, HRB.

of the 4,000-odd patients who passed through the center resulted in the conclusions that an enriched diet aided recovery and that the patient could move about the ward, even safely take part in vigorous exercise during convalescence. Following their patients through reconditioning at the Camp Nara convalescent center on Honshu, the team gained an overview of the course of the disease that brought significant changes in its clinical management.⁴⁰

Under the pressures of war such convalescent centers had emerged in late 1950 as an important aid to the Japan Logistical Command's effort to handle its huge patient load with deficient resources. The centers quickly proved a boon to patients as well. From an administrator's viewpoint much smaller medical staffs could handle recovering patients at such centers, freeing bed space for incoming wounded and seriously ill. But the centers developed an atmosphere and synergy all their own. Different kinds of patients—recovering wounded, neuropsychiatric cases, the physically injured who manifested a reluctance to get well—helped to heal one another. Lt. Col. John L. Mothershead of the Medical Corps summed up the mission of the Camp Nara center: "Hold the patient until nature heals the injured part, keep the soldier patient's general physical and mental condition to as high a level as possible, and bring the effected [*sic*] part back to normal or as near normal as possible."⁴¹

The program aimed in part to make patients well by encouraging (or, if necessary, compelling) them to act well. Patients not confined to bed wore uniforms, lived in barracks, made formations, and stood inspections. Traditional therapies were modified. In place of the lengthy bed rest then prescribed for hepatitis victims, Nara emphasized early ambulation. Former hemorrhagic fever patients displayed a sometimes alarming array of symptoms as sequelae of their disease. All symptoms tended to disappear during conditioning, though the patients' urine had to be carefully monitored to ensure that their kidneys were returning to full function.⁴²

For neuropsychiatric casualties, centers like Nara proved especially suitable. Such men mixed into the general population of recovering wounded. Often the conventional hospital was far too comfortable a place to convince the psychoneurotic that he should seek to rejoin the world of ordinary people. Here psychiatric patients found little sympathy for their symptoms, and the daily round of exercise and normal unit activities, among men wearing fatigues not pajamas, brought many out of the world their fears had created. Even their attitude toward psychiatrists improved. In an ordinary hospital the patients tended to regard their doctors as obstacles to evacuation; in the more bracing atmosphere of convalescent centers they sought them out as friends.

The convalescent hospital at Camp King, Omiya, Honshu, began its existence as the 8079th Evacuation Hospital, Semimobile, apparently bound for

⁴⁰Thomas C. Chalmers et al., "The Treatment of Acute Infectious Hepatitis: Controlled Studies of the Effects of Diet, Rest, and Physical Reconditioning on the Acute Course of the Disease and on the Incidence of Relapses and Residual Abnormalities," *Journal of Clinical Investigation* 34 (July 1955, pt. 2): 1163–235.

⁴¹United States Army Hospital, 8040th Army Unit, Annual Report of Medical Service Activities, 1952, p. 2, file 319.1–2 (U.S. Army Hospital, 8040th Army Unit) Far East–1952, HRB.

⁴²Ibid., pp. 3–4, HRB.

field service. Instead in December 1950 the organization was redesignated as Station Hospital, 8079th Army Unit, with the mission of operating a convalescent center. The unit took over a group of large concrete industrial buildings, a former lens and instrument factory, which most recently had served as barracks for the 1st Cavalry Division. While reconstruction went on, the 8079th received its first group of salvageable patients whom it was to guide back to duty status. Among them were surgical, medical, and neuropsychiatric cases. At year's end none of these patients had to be evacuated to the zone of interior, and only four neuropsychiatric cases had proved refractory.

During the two years that followed, uncommonly complete reports gave a detailed picture—literally, for the reports were illustrated by snapshots—of a convalescent center at work. A walled-in compound of about 100 acres, Omiya provided its ambulatory patients bathing and latrine facilities which were described as “adequate on an austere basis.”⁴³ Apparently life there could be characterized in similar terms. Despite its industrial origin the site was pleasantly landscaped, with lawns and shrubbery and a 15-acre turfed field for athletics and drill, of which there was a great deal. As the commander's formal orientation lecture candidly declared, the center stood midway between a hospital and a rerun of basic training, with the daily schedule a round of calisthenics, therapy, lectures, and drill.

Patients were divided into four classes, from those still in bed to those ready to return to duty. Therapy and exercise were geared to each group's capabilities. Included for the nearly well were road marches of up to 8 miles through what a report termed the “rural picturesque environs of the post”; such marches were alleged to be “enjoyable as well as essential to military conditioning.”⁴⁴ Repeated physical exams monitored the patient's progress, and a final one at his departure assigned him a physical profile that helped to determine his future assignments. Among the men who passed through Omiya were soldiers of all the U.N. contingents, except those of the British Commonwealth and South Korea. Thirty-nine hundred patients were admitted in 1952. More than thirty-five hundred were Americans; the rest were Belgian, Colombian, Ethiopian, French, Greek, Dutch, Filipino, Thai, and Turkish fighting men.

As might be expected, recovered vigor created some problems of its own. Much of the commander's lecture to newcomers dealt with venereal disease. “Failing [abstinence],” which was evidently regarded as unlikely, the soldier was urged not to “*mix liquor and women* because you could then better remember to use a rubber from beginning to end of each act, to take a *Prophylaxis* afterward, and to *lubricate* your rubber with some of the ‘pro jelly’ to lessen it's [sic] chance of breaking.”⁴⁵ Such adjurations at any rate indicated a rapid return to normal on the part of many convalescents.

Such were the two roads followed by most casualties entering Japan: evacuation to the zone of interior or, via the convalescent centers, back to duty within

⁴³United States Army Hospital, 8079th Army Unit, Annual Report of Medical Service Activities, 1951, p. 2, file 319.1–2 (U.S. Army Hospital, 8079th Army Unit) Far East–1951, HRB.

⁴⁴“Handling of Convalescent Patients at Convalescent and Rehabilitation [sic] Center United States Army Hospital 8079th Army Unit, Omiya, Japan,” p. 31, attached to *ibid.*

⁴⁵*Ibid.*, encl. 3, p. 4, HRB.

the Far East Command. It would be satisfying to report that all followed either one course or the other. Obviously, they did not.

Official reports hide more than they reveal of any patient's experience, his suffering, the alternations of hope and despondency, and the labors and occasional failures of the medics. Case reports are at least suggestive of this inner aspect of a history that otherwise must appear formal and remote from the smell of real events. On 8 July 1951 in Korea a twenty-year-old soldier was wounded in the side and groin by shell fragments. That same day the 8076th MASH operated, excised a part of his small intestine, and repaired some small perforations in the gut. At first all went well. When the patient reached the 279th General Hospital in Japan, his incision was already well healed. But on his second day in the hospital he suddenly felt a severe pain in the groin and upper thigh. Physical examination showed nothing. He continued to complain, now of pain in his side radiating to the groin. He began to run a low temperature and his white blood count rose. A soft mass could be felt under the skin of his flank.

X-rays revealed a small ragged bit of metal lying near the spine. Tests showed the red blood cell count to be down, despite the transfusion of a unit of whole blood. Clearly, the soldier was bleeding internally. The question was where.

He was taken to the operating room. As the surgeon thrust a knife into his flank "there resulted an outpouring and gushing of bright red blood."⁴⁶ The doctors now knew that a large artery, probably the abdominal aorta, had been injured and was leaking. But any exploration might bring on a fatal hemorrhage, and the shock of surgery was a danger in itself. While the doctors hesitated, the soldier received more whole blood and for a few hours showed no change. Then his blood pressure dropped suddenly, his pulse rose, and the bloody drainage from his side increased. The staff scrambled to find and match enough blood to keep him alive under the impending operation. On reentering his side the surgeon found the site of the hemorrhage hidden by masses of clotted blood behind the peritoneum. When the aorta was exposed, a sudden spurt of blood followed, which the surgeon controlled by pressing with his fingers. Ligatures were tried in various places, but the bleeding stopped only when the aorta itself was tied.

After five and a half hours the operating room team still had not located the site of the bleeding. The boy's blood pressure was dangerously low, his breathing shallow and rapid, despite the administration of whole blood. He died within an hour of the trauma of surgery, the only alternative to dying of slow internal hemorrhage. On the autopsy table a pathologist at last found the rent in the abdominal aorta, just above the point where it divides to form the iliac arteries, a little below the level of the navel. Immediately behind the injury was the metal fragment, which was about two centimeters (eight-tenths of an inch) at its greatest diameter. "No, 'tis not so deep as a well," said Shakespeare's Mercutio of his own fatal wound, "nor so wide as a church-door; but 'tis enough, 'twill serve. . . ."⁴⁷

⁴⁶279th General Hospital, Annual Report of Medical Service Activities, 1951, p. 44, file 319.1-2 (279th General Hospital) Far East-1951, HRB.

⁴⁷Ibid., pp. 44-45, HRB. Quoted words from *Romeo and Juliet*, act 3, scene 1.

The hospitals stood between the battlefronts and the peaceful urban world of the Japanese cities, in contact with both. The harshest evidence of war and the normal ways of peace mingled in the wards and halls; acrobats and comedians performed among the burned and battered, while newly arrived staff members trailed veteran physicians on the ward rounds. On pass, convalescents tested their returning strength in old-fashioned hell-raising. But the wounded were everywhere, in hospitals and annexes, their beds crowding schoolrooms and corridors, the centerpiece of all the activity, inescapable reminders of the war forty minutes away beyond the Korea Strait and the Sea of Japan.

The Way Home

Even before the war the Army regularly evacuated from Japan to the zone of interior patients whose hospitalization was expected to last longer than 120 days. During the first six months of 1950 the number of evacuations averaged 223 a month, 91 percent of them by air. With the onset of war the number began to rise dramatically: 513 in July, 1,269 in August, and 5,014 in September. The swamping of the hospitals during late August and early September compelled the Japan Logistical Command to jettison its traditional policy and evacuate purely in order to reduce the hospital census to a manageable level. The usual procedure of having each evacuee approved by a medical board was dispensed with. During September, for the only time that year, a large number of patients—almost 1,400—were moved by ship, as emergency measures took precedence over a Department of Defense policy in effect since September 1949 that planes normally should be used for moving military patients.⁴⁸

Efforts to regularize the evacuation process had strictly limited success. By early December the Japan Logistical Command's standard operating procedure (SOP) was in place. An evacuation officer in the office of the JLCOM surgeon coordinated movement of patients to the zone of interior under the restored 120-day policy. During the wild days of September the command had allowed a number of hospitals, including station hospitals, to process evacuees. Now evacuation took place only through the Tokyo and Osaka Army Hospitals and the 361st Station Hospital at Tokyo, where disposition boards sat regularly to pass on cases requiring long-term care in the United States. Patients embarked at Haneda International Airport in Tokyo or Itami Air Base in Osaka, passing with their records into the hands of MATS' 1453d Medical Air Evacuation Squadron. Regulations provided for complex bureaucratic procedures—records were to be delivered at least twelve hours before the estimated time of departure, for example, and were to include "sixteen (16) copies of the evacuation order for

⁴⁸JLCOM, Annual Report of Medical Service Activities, 1950, p. 31b, HRB; Encl. 30 Nov 50, sub: Medical, p. 6, tab 4, document 3, Medical Section, JLCOM, Command Report, 1–30 Nov 50, Narrative Summary [and Documents], file AYUT–8000, Annex 24 (Medical Section, JLCOM, Nov 50), Box 4623 (JLCOM, AYUT–8000, Annexes 19–28, Nov 50), Entry 429, RG 407, MMFB; JLCOM, Report of ETMD, September 1950, p. 5, file 350.05 (ETMD, Far East, JLCOM, 1950), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112, MMFB. On Department of Defense policy, see U.S. Department of Defense, *Semiannual Report of the Secretary of Defense . . . , 1 July to 31 December 1949* (Washington, D.C.: Government Printing Office, 1950), p. 119.

each patient," plus an array of clinical and service documentation. This SOP bore the date 5 December. During that same week admissions to the hospitals in Japan quintupled—7,224 new patients in seven days. Such variations could not be predicted, a fact which alone precluded careful scheduling, and by the end of the year the command admitted that projections for more than two weeks ahead were without much value. The evacuation policy had to be lowered again, and four more hospitals were designated to process patients. In December—the peak month for 1950 and the war—6,401 casualties were evacuated from Japan to the United States.⁴⁹

Predictability increased markedly during 1951 and even more in the year that followed. Though spurts could still occur in response to sharp actions on the battlefield, the level of combat had been so lowered and the capacity of the hospitals in Japan so increased that evacuation policy remained constant and the demands on MATS well within its normal capabilities. Sea evacuation remained a small fraction of the total—about 2.6 percent during 1951 and eight-tenths of 1 percent during the first seven months of 1952.

U.N. patients in American care presented a special case. British Air Force planes evacuated British, South African, Indian, Australian, and New Zealand soldiers from the British Command of Forces hospital at Kure to Hong Kong, the first stop on the men's journey home. In April 1951 the United States offered a converted troopship, the USNS *General J. H. McRae*, as a hospital vessel to carry other U.N. patients. Staffed professionally by U.N. medical personnel, the ship bore 200 litter and 500 ambulatory cases to their homes in Thailand, Turkey, Greece, France, and Holland. Later, other ships were used for the same task. In mid-1952, for example, the USNS *General LeRoy Eltinge* evacuated 67 U.N. patients. Space on American ships was provided during 1952 on a reimbursable basis, and such vessels departed periodically from Yokohama, eliminating a backlog that had developed when only one ship was available. American ships carried the vast majority of U.N. wounded, though British aircraft or commercial vessels carried a few, and the Danish hospital ship *Jutlandia*, on its return to Copenhagen in April 1952, bore a load of U.N. patients to their various homelands.⁵⁰

While the Military Sea Transportation Service handled the European and Near Eastern soldiers, and the British took care of their own, Western Hemisphere casualties entered the MATS system. Canadians were carried by plane to the United States for later transfer to hospitals of their own nation; Colombians to Brooke Army Hospital for transportation home; and soldiers of the Philippines, if seriously wounded, to Clark Air Base for disposition.

For Americans, naturally, the question of greatest interest was the transfer of their own wounded. For many an injured man, an Army or Navy hospital of the zone of interior was his final destination within the military medical system, the place where medical science would make its final, most sophisticated effort to

⁴⁹Quoted words from Headquarters, JLCOM, Command Report, December 1950, Narrative Summary, p. 86, RG 407, MMFB. See also JLCOM, Annual Report of Medical Service Activities, 1950, pp. 28–30, HRB. The latter source elsewhere gives the December evacuation total as 6,382.

⁵⁰FEC and USAFFE, Annual Report of Medical Service Activities, 1952, p. 30, HRB; FEC, Report of ETMD, July 1952, p. 3, HRB; Headquarters, JLCOM, Command Report, 1–30 Apr 51, Narrative Summary, pp. 71–73, 76, file AYUT-8000 (JLCOM, Command Report w/Supporting



OFF-LOADING A MATS PLANE AT HICKAM AIR FORCE BASE

discharge him in condition to live out the remainder of his life in reasonable health.⁵¹

Zone-of-Interior Hospitals

After a brief rest stop and a hot meal at Midway Island, MATS evacuation planes flew nonstop to Hickam Air Force Base, Hawaii. Here litter patients were unloaded into bus ambulances for the short drive up Moanalua ridge to the 375-acre reservation of sprawling Tripler Army Hospital. Occupying one of the most beautiful sites of any military hospital, most of Tripler's rooms had lanais and views of the ocean. Tripler showed the effects of unification—Army, Navy, and Air Force personnel staffed it—and of the usual personnel shortages, intensified by the war. After August 1950 civilian orderlies relieved service people of much basic work, and civilian laborers unloaded the litters of evacuees from the buses.

When they arrived, at any hour of the day or night, patients were checked by the appropriate chief of service or his representative and then assisted to the air evacuation wards. During 1950 alone, more than 11,400 battle casualties passed through these wards. Here the patient was put to bed, fed a hot meal, and

Documents, Apr 51), Box 4853 (JLCOM, AYUT-8000, Narrative w/encls, Apr 51), Entry 429, RG 407, MMFB.

⁵¹JLCOM, Annual Report of Medical Service Activities, 1952, p. 20, HRB.



AMBULANCE BUSES EN ROUTE TO TRIPLER ARMY HOSPITAL

bathed. All hospital services—medical, surgical, and psychiatric—pitched in to treat any who needed help before resuming the flight to the zone of interior. Problems that had developed or worsened in flight were attended to, as the orthopedists checked and cut casts, psychiatrists observed the neuropsychiatric cases, and so forth. As in Japan local entertainers appeared; pretty girls draped leis over the foolish grins of pajama-clad soldiers and marines; on holidays, local hotels invited the ambulatory to their parties; and the Red Cross Gray Ladies, as ever, were on hand to provide small comforts. Celebrities came and went—President Truman during 1950, Vice President Alben Barkley in 1951, plus many of the same entertainers who played the camps and hospitals of Japan and Korea. As a first taste of home, Tripler had its charms and its serious functions as well.

After a stay averaging between twenty-four and forty-eight hours, the patient was ready for the next leg of his journey. If he was a Westerner, he flew to Travis Air Force Base north of San Francisco; if an Easterner, to Lackland Air Force Base in Texas. In either case his next stop was the Air Force hospital serving the base, where his presence and condition were reported to the Armed Services Medical Regulating Office in Washington, D.C. Here the hospital nearest his home that could serve his particular needs was selected as the site for his definitive treatment.⁵²

⁵²Tripler Army Hospital, Annual Reports of Medical Service Activities, 1950, app. XIII, and 1951, p. 89, files 319.1–2 (Tripler Army Hospital) Far East–1950 and –1951, HRB.

War had hit the Army hospital system hard. Years of contracting budgets and manpower difficulties had culminated, in early 1950, in the closing of four general hospitals—Murphy, Oliver, Valley Forge, and Percy Jones. In consequence, the double pressure to meet the needs of an expanding Army while caring for the most serious and long-term Korean casualties could not be met. Fortunately, Korea was largely an Army war, and among the other services only the Marine Corps sustained large numbers of casualties. The availability of beds in Navy hospitals provided an early key to meeting the burden imposed by heavily wounded men who required much special handling and skilled treatment. In October 1950 the Joint Chiefs of Staff set up the Armed



COMFORTS OF HOME AT TRIPLER

Services Medical Regulating Office under the chief of staff of the Army to perform the basic function of matching patient to bed on an interservice basis. By this time 1,875 Army battle casualties were already in non-Army hospitals, as against 1,796 in Army installations. Thereafter, the reopening of three of the closed hospitals (Murphy, Valley Forge, and Percy Jones) and the redesignation of others as specialized treatment facilities rapidly improved the prospects for treating Army patients in Army beds. The number of soldiers in Navy hospitals fell to only 165 in August 1951. Nevertheless, the Army owed much to its sister service for its aid in handling the 13,000-plus evacuees who had flooded in during the first year of the war.⁵³

The zone-of-interior hospitals exhibited familiar problems in staffing. Typical of the conditions of 1950 was the Fitzsimons Army Hospital, 10 miles east of Denver. Ordered to reduce its civilian work force in April, the installation by June had abolished 156 jobs and made 127 reassignments to meet its quota. Then came the war. In July the hospital experienced a “drastic swing from contraction . . . to rush expansion” when civilian replacements were authorized for about 450 military personnel. By the end of the year stability had returned and about five hundred new civilian employees were on the payroll. During 1951, when the shortage of nurses became acute, new patient care procedures supplemented more customary expedients. Patients, according to their illness, were divided between “hospital” wards and “clinic” wards. The hospital wards were for those who needed close attention and care by the

⁵³Resources Analysis Division, OSG, Summary of Activities, 25 Jun 50–8 Sep 51, p. 1, file 314.7–2 (Army Medical Service Activities, 25 Jun 50–8 Sep 51); Charter of the Armed Services Medical Regulating Office in SG Conference Notes, 25 Oct 50. Both in HRB. See also Byron L. Steger and Donald E. Domina, “Armed Services Medical Regulating Office,” *United States Armed Forces Medical Journal* 2 (July 1951): 1101–04; Speech, Maj Gen George E. Armstrong, Deputy

(Continued)

available professional staff, whereas the clinic wards were for those who required minimum attention—in some cases by enlisted personnel only (“and,” noted a report, “by the minimum possible number of those”).⁵⁴

As in Japan a rapid growth of facilities accompanied a declining influx of patients. The swelling of the Army, and the consequent need to provide medical service at new or expanded training camps, justified an expansion that continued until the middle of 1952. Thereafter, allocations began to fall, the Army losing 2,500 bed authorizations as the new fiscal year began and the Navy 2,200, with further reductions to come in January 1953. The uncertainty of the negotiations in Korea, the potential for a renewed outbreak of fighting, and the possibility of a widened war that burdened all official thinking meant that a substantial number of reserve beds had to be maintained. But the trend was clearly enough in the other direction that the expanded hospital system took a severe cutback in mid-1953, when the number of beds available throughout the military hospital system was reduced from about 113,000 to a little over 95,000. At the time about 54,000 of these were occupied, 46,000 by military patients and the rest by dependents. Meanwhile, construction of new hospitals was to be held to a minimum, as the events of spring and early summer clearly foretold the end of the war.⁵⁵

Selected Hospitals

Many men of Western origins underwent definitive treatment at the Fitzsimons Army Hospital. The huge 2,300-bed hospital, employing over three thousand military and civilian workers, provided sophisticated care in all fields, though it was known particularly as a tuberculosis center. Standing some 5,300 feet above sea level in the foothills of the Rockies, with abundant sunshine and low humidity, it offered an attractive setting both to staff and patients. Like the large hospitals in Japan, Fitzsimons was to some extent a community in itself, with clubs and sports teams, library and theater, music room and greenhouse, hobby shop and nursery, chapels, and even its own radio station, KFG. Celebrities visited and showmen performed. The hospital staff arranged trips for convalescent patients to sports events, concerts, and rodeos, and the patients did some entertaining of their own, addressing Denver clubs and veterans' groups on patriotic themes, urging blood donations and support for the men in Korea, and telling war stories.

(Continued)

Surgeon General, DA, to Indiana State Hospital Association, French Lick, Ind., 23 May 51, “evacuation and hospitalization in the Korean War,” in George Armstrong Papers, Book 4, Box 2, Medical Historical Unit Collection, Archives, U.S. Army Military History Institute, Carlisle, Penn.

⁵⁴Fitzsimons Army Hospital, Annual Reports of Medical Service Activities, 1950, pp. 18–20, and 1951, pp. 81–84, files 319.1–2 (Fitzsimons Army Hospital) Far East–1950 and –1951, HRB.

⁵⁵U.S. Department of Defense, *Semiannual Report of the Secretary of Defense . . . , 1 January to 30 June 1952* (Washington, D.C.: Government Printing Office, 1952), p. 27; Thirty-second Meeting of the Armed Forces Medical Policy Council, 21 Jul 52, file 334 (AFMPC), Box 32, Accession no. 58A–1095, RG 112, WNRC; Resources Analysis Division, OSG, History of the Korean Conflict, September 1951–January 1953, pp. 1–2, file 314.7–2 (Army Medical Service Activities, 9 Sep 51–31 Dec 52), HRB; U.S. Department of Defense, *Semiannual Report of the Secretary of Defense . . . , 1 January to 30 June 1953* (Washington, D.C.: Government Printing Office, 1953), p. 32.

Korea impacted on the hospital in many ways. Veterans' Administration patients were the big losers, for all except a few under treatment for tuberculosis were moved out of Fitzsimons. With their departure the need for beds on the medical wards fell drastically. The surgical service expanded. The obstetrical and gynecological service had particular problems, many of its staff departing for service in the Far East Command that presumably would include more bullets and fewer babies. Fitzsimons was a teaching hospital with residents to train; their number fluctuated during 1950, rising as other teaching hospitals closed, falling again as residents were sent to the Far East to replace the Army Specialized Training Program graduates, and still further with the advent of war. Personnel turbulence was the rule among the military as among the civilians, though for different reasons. By the second year of the war the problem with enlisted people was not a lack of bodies but the rapid replacement of the trained by the untrained, the veteran by the newcomer.

In the surgical service, where most of the wartime action was, cases of great complexity were common. For many a patient this was the last link in the chain of evacuation, the place of final resort for care and healing. The most common injuries included severe vascular and nerve cases; large soft-tissue wounds, with much flesh destroyed; wide and deep burns; and embedded missiles and fragments. Multiple wounds often were seen. A single patient might have a chest wound, clotted blood and pus in his chest cavity, fragments in his lungs, and lesser wounds in the abdomen, arms, and legs. Close cooperation among the different surgical specialists was essential, because the same man might have orthopedic, thoracic, and urologic injuries. Standard procedure, however, went beyond such technical cooperation in attempting to treat the whole man.

When a wounded man reached Fitzsimons, he not only had serious injuries but also had traveled far. On the average, he had lost about 20 pounds of body weight and the habit of eating as well. He often was confused, disoriented, and depressed, his will to live sapped by pain, tedium, and the infantile state of physical helplessness to which he had been reduced. His first need was nourishment and reassurance, his second to get moving as soon as possible and as much as possible. He must learn to do as many things for himself as he could; he must walk if he could manage it. The sense of dependency was an integral part of the apathetic state that obstructed recovery.

Then came the surgical centerpiece, the "correction of the primary defect."⁵⁶ With the time and equipment to do thorough explorations, surgeons could often find the source of baffling problems. In persistently draining sinuses, for example, they might find osteomyelitis (bone infection), sometimes caused by a missile fragment lodged at some distance from an original maxillofacial wound. Other procedures were the final step in a long series of surgical interventions that had begun in Asia. Patients with colostomies, as part of learning to care for themselves, were taught to clean the opening through which their bowels drained. Then, after any injuries to the buttocks and perineum were healed, surgeons opened the patient's belly, cut the exteriorized section of the bowel, and sutured the severed ends of the intestine (end-to-end anastomosis), restor-

⁵⁶Fitzsimons Army Hospital, Annual Report of Medical Service Activities, 1950, p. 107, HRB.

ing normal function. The influence of the Far East Command surgeons was felt at every step during work in the zone-of-interior hospitals. Orthopedic surgeons found their work lightened by the excellent care given in Korea and Japan, where medics had applied casts on broken limbs competently, set fractures carefully and firmly, and accomplished amputations properly. On the whole, one gains the impression that the purely surgical work, demanding as it was in all aspects of knowledge and technique, was the least uncertain part of the process of restoration and recovery.

The last phase was as important as those that went before it. By therapy and exercise the staff aimed to rehabilitate the patient to the point where he felt, looked, and thought of himself as a complete and healthy man. Clearly, in view of some of the injuries they faced, this could only have been an ideal; but as an ideal it was by no means a poor one. Only when the process was judged as complete as possible did the former patient receive his proper reward, convalescent leave or a furlough home.⁵⁷

Some injuries were so massive that little could be done to dispel the cloud that hung over the victim's future, Murphy, for example, recorded a surgical attempt to relieve persistent urinary problems in a paraplegic who had also lost three limbs. Percy Jones during 1951 had at least one quadruple amputee, whose state the Office of the Surgeon General did not want to see "publicized any more than necessary," presumably to shield the public from uncomfortable truths about the fighting in Korea. For patients requiring long-term care and expert rehabilitation the hospitals of the Veterans' Administration usually were the next step after they left the Army hospitals.⁵⁸

Not all the damage of the war was so severe, and not all was physical. In the Brooke Army Hospital at Fort Sam Houston, Texas, one of the psychiatric patients was a twelve-year veteran, a former master sergeant broken to corporal for striking an officer who had sent him on a disastrous patrol in Korea. He had served in combat throughout the months of fighting in 1950; he exhibited a stable and pleasing demeanor; and, in short, he was not the usual neuropsychiatric casualty. His chief symptom was an inability to speak above a whisper—a significant one in a man whose work had consisted so largely in giving voice commands. No physical cause could be found, and he was evacuated first to Japan and then to the zone of interior. During a lengthy interview under pentothal he finally ceased to be as guarded about his feelings as in previous treatment, freely describing his resentment over the failings of the combat units in Korea and his sense of guilt over several brothers who had died in World War II. Within an hour he had begun to speak normally, and when last heard from by the staff a few months later, he was having no further difficulty.⁵⁹

⁵⁷Ibid., 1950, pp. 2, 62–63, 67, 71, 82, 106–08, 113, and 1951, pp. 76, 117, HRB. See also *ibid.*, 1952, pp. 78–79, file 319.1–2 (Fitzsimons Army Hospital) Far East–1952, HRB.

⁵⁸Quoted words from SG Conference Notes, 12 Jan 51, HRB. See also Memo for the President, sub: Utilization of Beds in Veterans' Administration Hospitals for Armed Forces Casualties, in *ibid.*, following entry of 19 Jan 51, HRB.

⁵⁹Brooke Army Hospital, Annual Report of Medical Service Activities, 1951, pp. 65c–66c, file 319.1–2 (Brooke Army Hospital) ZI–1951, HRB.

Among the eastern hospitals, Washington's major center at Walter Reed received a heavy influx of Korean casualties. At least in general outline, however, its problems—with staffing, the increase in the number of surgical beds, and the need for a convalescent annex (in this case at Forest Glen, Maryland)—closely resembled those of Fitzsimons. Special problems did arise in the hospitals that were closed in the spring of 1950 only to be reopened in the fall to accommodate the needs of an increased Army and the Korean wounded. Murphy Army Hospital, 12 miles east of Boston, was one of these. Standing on 93 acres of elevated land, the hospital consisted of forty-four brick buildings in a simplified Georgian design. Though short a gym and swimming pool, it was in other respects a typical hospital complex, and a well-equipped one prior to its inactivation on 1 May 1950. At its rededication on 1 November bands played, Deputy Surgeon General Armstrong spoke, tea was served at a reception in the mess hall, and forty-six guests repaired later to the 1775 House restaurant in Lexington for a dinner party.

By this time Col. James B. Stapleton, the new commander, knew that conditions in the hospital were less than perfect. In fact, the six months of deactivation proved disastrous. The standby crew of caretakers were selected for their jobs because they lived nearby, not because they were experienced or competent. Complex machines were stored improperly and required extensive repair; the clubs and officers quarters were stripped of furniture and equipment for other Army posts; and the medical library was without books. What remained was anything that “neighboring installations did not want or could not use.” Stock records showed supplies that were not there. Funds were short, and many of the new complement, especially among the enlisted people, inexperienced. By the end of 1950 Murphy was back in business, treating, among many others, Korean cold injury victims. But the effects of deactivation were yet to be fully repaired.⁶⁰

At another one of the hospitals that also was closed and then reopened—the Percy Jones Army Hospital in Battle Creek, Michigan—occurred a case that may serve as the conclusion to this chapter. With every technique that medicine could offer, recovery still depended at the last on the ability of the patient to endure much, including many setbacks, and often to face at the end of his ordeal a lasting handicap. In June 1951 a 21-year-old serviceman—there is no way to tell from the report whether he was a soldier, though this seems likely—suffered in his right shinbone one of the crushed and shattered open fractures that were so typical of the war. A month later he arrived at Percy Jones from another zone-of-interior hospital for an amputation, for which surely he must have appeared a likely candidate. From his half-healed wound, oozing foul-smelling pus, two fragments of shattered bone protruded; X-rays showed that 8 inches of the tibia were crushed and the fragments dispersed.

⁶⁰Quoted words from Murphy Army Hospital, Annual Report of Medical Service Activities, 1950, p. 5, file 319.1-2 (Murphy Army Hospital) ZI-1950, HRB. See also *ibid.*, pp. 3-6, HRB; Walter Reed Army Hospital, Annual Report of Medical Service Activities, pp. 116-17 and 253, file 319.1-2 (Walter Reed Army Hospital) ZI-1950, HRB.

Nevertheless, the surgeons decided not to amputate. They debrided the wound and put the leg in a long cast. By September, the young man had begun to feel sensation in his foot for the first time since he was wounded. But in October he developed serum hepatitis, which ran its course. In November doctors found evidence of a bony union of the tibia. Sensation steadily returned, and in February 1952 surgeons covered the remaining wound with a skin graft. However, the patient's toes still had no sensation and in May he burned them against a heater. The burns healed. By the next month—it was a year since his injury—sensation had returned throughout the whole foot, and the break had healed sufficiently that the orthopedists could put him into a brace instead of a cast. The injured leg was about an inch shorter than the other, and the flexion of the knee was imperfect. But by year's end he still had his leg, and he was walking.⁶¹

To those who traveled the long way home through the medical evacuation system, definitive care could mean many things. To the worst injured it might mean little more than the dubious prolongation of a burdensome existence. For many it meant complete—or almost complete—recovery, an opportunity to resume interrupted lives and to pursue careers that had seemed lost. To others it meant a tolerable compromise with defects that could have been far worse. To the hospitals themselves it meant, especially for the surgical staffs, an opportunity to learn as well as to treat; to practice and refine skills; to develop new techniques and expand medical knowledge of the many faces of trauma. At their best the hospitals provided a setting where the patient's fortitude and the healing art could meet to the lasting benefit of both.

⁶¹Percy Jones Army Hospital, Annual Report of Medical Service Activities, 1952, p. 191, file 319.1-2 (Percy Jones Army Hospital) ZI-1952, HRB.

CHAPTER 10

Victims of War

The United Nations Command wrote much of the medical story in Korea by responding to the needs of prisoners of war (POWs), refugees, and the plain people of the embattled South Korean nation. Across the lines, meanwhile, imprisoned medical personnel attempted to aid their fellow POWs in Communist camps. In both cases, medics had to deal with the fact that in Korea the war continued behind barbed wire.

The lot of POWs seldom has been happy. Incarceration does not usually bring out the best in either prisoners or guards, and when the two are by definition enemies, good treatment of captives becomes even less likely. Improved conditions for prisoners date in Western history from the late seventeenth century, when professional armies began to emerge out of the chaos of the religious wars. The eighteenth century saw leading thinkers of the Enlightenment begin to work out a code, which—further elaborated in the next century and ultimately written into international treaties—defined the prisoner of war as a man who was out of the battle, entitled to decent treatment, and in some cases to exchange. Even in the often barbarous Second World War, Western nations generally attempted to observe the provisions of the various international accords with respect to each others' captives, though atrocities did occur. Treatment of other peoples was another matter. The Germans, in dealing with Slavic POWs, compiled the worst record of the entire war.¹

Asiatic nations appeared to regard prisoners much as Westerners did before the Enlightenment—as enemies disarmed but still hostile, to be ransomed, killed, or enslaved at the pleasure of their captors. In the Pacific war the Japanese demonstrated gross brutality and neglect in their treatment of POWs, resulting in extraordinary death rates. The record of the Pacific fighting promised a hard fate for those who fell into North Korean (or South Korean) hands, for the bitterness of civil strife and competing ideologies further inflamed the passions of wartime. Neither Korean nation was a signatory to the Geneva Conventions of 1949, which embodied the most recent statement of prisoners' rights, nor was the People's Republic of China, after it intervened. The United States had signed the accords but had not yet ratified them.

¹Howard S. Levie, *Prisoners of War in International Armed Conflict*, International Law Studies, vol. 59 (Newport, R.I.: U.S. Naval War College Press, [1978]), p. 5.

In the event, all participants followed their own customs and ideals. The United States generally upheld the spirit of the conventions and established Western traditions. China and, to some extent, North Korea behaved as their experiences in revolutionary war and the theories of communism demanded. Meanwhile, casual brutality too often reigned at the level where the armed soldier lorded it over the helpless prisoner. At no time did one side or the other monopolize cruelty. "I think," said Colonel Dovell, "that I can say with impunity that all cats look the same in the dark. I say this because when it came to cruelty to the other side there was no difference between the North Korean and the South Korean."²

U.N. Prisoners: The First Phase

In almost every way, Americans captured during the summer of 1950 were the most unfortunate of all. Apparently North Korea had no policy for dealing with American prisoners in the early days of the war, simply because it had not anticipated encountering any. For South Koreans capture meant—if they were associated with the government—imprisonment and often execution; if not, and if they were males of military age, it usually meant impressment into the invading army. American prisoners, on the other hand, were customarily robbed and sometimes stripped of clothing and shoes and their wrists bound with telephone wire or their own shoelaces. What happened then seemed to depend on the impulse of their captors. In a few instances mutilated bodies recovered later by advancing United Nations (U.N.) troops proved death by torture. Many prisoners were driven toward the rear under conditions that would not have seemed strange to a Chinese poet who had written eleven hundred years before:

The captives from the western tribes
Were driven into Ch'ing with ears pierced, faces broken. . . .
Bodies thick with wounds, faces bruised with sores
Sick to death they traveled a post length each day.³

When Philip Deane was captured, he was stripped to his shorts, his hands were bound, and with other prisoners he was driven north along the roads, fed little, permitted to drink from rice paddies, and at Korean villages beaten and kicked by the residents. A North Korean officer told him later that at first there "had been no policy" regarding war prisoners. Then the policy was enunciated

²Quoted words from Dovell Interv, 21 Sep 66, p. 12, Personal Interviews file (Dovell), HRB. See also Levie, *Prisoners of War*, pp. 507–10; Cohen and Copper, *Follow-up Study of World War II Prisoners*, pp. 15–24. Communist allegations of atrocities against prisoners by Americans form a substantial body of material whose evidentiary value seems impossible to assess. See, for example, *Out of Their Own Mouths: Revelations and Confessions of Torture, Rape, Arson, Looting, and Cold-Blooded Murder of Defenceless Civilians and Prisoners of War in Korea* (Peking, 1952) and various publications by Wilfred G. Burchett, including *Koje Unscreened* (Peking, 1953).

³Po Chu-i (772–846 A.D.), "Captives From the Western Tribes," in Robert Payne, ed., *The White Pony* (New York: New American Library, 1960), p. 211. The captives were Tartars. A post length was about 20 miles.

that they were to be “treated kindly.” Deane, as a newsman of some celebrity, suddenly found himself clothed, offered medical treatment, and fed eggs and other delicacies. Some American soldiers who survived their initial ordeal appear to have gone through a similar period of somewhat better treatment. Capt. Alexander Boysen, a battalion surgeon of the 24th Infantry Division captured near Chochiwon, lived first on rice balls and water and saw many fellow prisoners whose shoes had been stolen. In Seoul and later at Pyongyang, however, his group had more food and some medical care.⁴

The change in policy reflected an enduring fact of the Korean War, its ideological character. As potential sources of propaganda the prisoners had an intrinsic worth denied them in many earlier wars. Furthermore, communism was an ideology that professed humanitarian concerns and aspired to universality. The prisoner was therefore a potential convert, and the practice in the Chinese and North Korean armies of impressing captured opponents into their ranks may have deluded their leaders into believing that Americans and other U.N. troops could be transformed from enemies into allies. The fact that the rhetoric of peasant revolutionaries merely would bore, or baffle, most Western prisoners apparently was never really understood or accepted.

The early phase of relative good treatment was short-lived, in cases where it existed at all. The collapse of the North Korean Army during September 1950 and the simultaneous approach of winter boded ill for the prisoners. Driven north to prevent liberation by U.N. forces, they endured cold and renewed privation. Several massacres occurred when recapture seemed imminent. As discipline dissolved in the remaining North Korean units, the stage was set for acts of individual cruelty by guards who stole prisoners’ clothing in bitter weather, denied medicine to the sick, and administered random beatings. Both Deane and Boysen fell into the power of a security policeman called the Tiger. During a ten-day death march soldiers and civilian internees, men, women and children, walked 75 miles and eighty-one died. They moved at night, in Siberian winds across the northern mountains, ill-clothed and starving, racked by dysentery,



AMERICAN ATROCITY VICTIM

⁴Quoted words from Deane, *I Was a Captive in Korea*, p. 88. See also *ibid.*, pp. 86–87; Rpt. Grant, Operation BIG SWITCH, pp. 11–13, file 383.6 (Operation “Big Switch”) 1953, HRB. Prisoners’ experiences varied greatly; not all benefited from a period of improved treatment.

often executed summarily if they fell by the roadside or stopped to defecate. The living stripped the dead, leaving them naked.⁵

The condition of prisoners rescued during the rapid U.N. advance called for quick medical aid. Col. Wayne S. Hume, surgeon of the 1st Cavalry Division, encountered at Pyongyang a prison camp with thousands of South Koreans "literally rotting away with untreated wounds." The 8055th MASH provided help. While Army engineers piped water into the compound from the Taedong River, medics treated the worst cases and the evacuation of the rest began by air. The main burden fell upon the division's clearing company, and upon the Eighth Army hospitals. Moving the victims out was the only practical possibility, for the prison area was grossly contaminated. After testing a barrel of rainwater intended for drinking, a medical officer remarked, "Can't you feel those amoebic cysts just crunching in your teeth?"⁶

Americans also were liberated. On 17 August Capt. Oree Gregory noted in her diary, "Our first American prisoners of war. Sad, happy, hungry, wounded, sick, lousy, cold—and very much afraid . . . even of fellow Americans. We did what we could." The men were flown to Japan as soon as they could travel. Here a battery of medical tests revealed that most were in better condition than expected, though all suffered from malnutrition (their diet had consisted largely of rice balls and barley), and almost all had sore feet, for their captors had stolen their shoes soon after capture and they had marched many miles. The code name ENOCH ARDEN was adopted for orders and correspondence dealing with the returnees and a repatriated allied military personnel center was established at Camp Zama. By the end of November 1950 the number of recovered prisoners totaled 251—15 officers and 236 enlisted men.⁷

For those survivors of the atrocities not fortunate enough to be liberated, a harsh time began in the makeshift prison camps—actually depopulated peasant villages—of extreme northern Korea. The winter was severe, even for that region; food was scarce; and the Chinese intervention had made their captors confident of victory without restoring order or reviving the policy of good treatment. "This was a phase," wrote five medical officers who survived, "of profound deprivation of all the necessities of life."⁸ Food was grossly inadequate. The Thanksgiving dinner for one group of five hundred men that November was one millet ball each and soup prepared by boiling nine heads of

⁵Deane, *I Was a Captive in Korea*, pp. 78–136; War Crimes Division, Judge Advocate Section, Korean Communications Zone, *Extract of Interim Historical Report, Cumulative to 30 June 1953*, pp. 11–26, LIB; Rpt, Grant, Operation BIG SWITCH, p. 13, HRB; Albert D. Biderman, *March to Calumny: The Story of American POW's in the Korean War* (New York: Macmillan, 1963), pp. 104–05; Clarence L. Anderson et al., "Medical Experiences in Communist POW Camps in Korea: Experiences and Observations of Five Medical Officers Who Were Prisoners," *Journal of the American Medical Association* 156 (September 1954): 120.

⁶Hume Interv, 19 May 66, HRB. First quotation on p. 13; second quotation on p. 14.

⁷Quoted words from Gregory, "An Army Nurse's Diary," 17 Aug 50, file 211 (Nurses) Korea, HRB. See also Headquarters, JLCOM, Command Report, November 1950, Narrative Summary, pp. 23–24, file AYUT-8000 (JLCOM, Command Report, Nov 50), Box 4619 (Narrative w/encls. 1–7, Nov 50), Entry 429, RG 407; Ltr, Maj Robert C. Buehrig, MC, Commander, 128th Station Hospital, to Surgeon, JLCOM, 21 Oct 50, sub: Summary Regarding UN POWs, in JLCOM, Report of ETMD, October 1950, pp. 45–46, file 350.05 (ETMD, Far East, JLCOM, 1950), Box 1 (ETMD, JLCOM, 1950–53 . . .), Entry 54B, RG 112. Both in MMFB.

⁸Anderson et al., "Medical Experiences in POW Camps," p. 121.

cabbage in water. Sanitation was nonexistent, as the men were crowded into small, unheated, verminous farmhouses. No clothing was issued until July 1951.

Medical conditions begged description. The lack of food and especially of animal protein combined with crowding and extreme cold to produce a new wave of deaths. At first most occurred among the wounded; then many who were uninjured died either from pneumonia or dysentery, or a combination of the two. Some who survived the first five or six months of captivity died later of deficiency diseases, mostly pellagra and beriberi. Testimony as to whether American doctors were permitted to treat fellow prisoners varies; some were, but many were not. Often enlisted men without medical training were obliged to care for each other and to perform such operations as pulling teeth with the aid of wires or wooden toothbrush handles. (Prisoners suffered severely with dental problems throughout their captivity.) "Hospitals" were simply huts where the moribund were confined to die, the most dismal of spots in a grim world, unheated, filled with dying men who sat in their own excrement, awaiting release. Occasional epidemics of typhus broke out among prisoners. Such conditions reflected to a great degree those existing among Chinese and North Korean troops, whose medical service was primitive and whose diet was sparse. But the enemy soldiers, armed and free to move about, got more of what little food was available in that devastated land.⁹

The spring of 1951 saw the most acute phase of the food shortage, some prisoners boiling weeds to provide additional sustenance. North Korea at this time was a veritable medical museum, with epidemics raging among the Communist forces and the population at large. At the same time, an influx began of Russian medicines, of health workers from China and other Communist nations, and a major public health effort by the North Korean government got under way. By midsummer the approach of peace talks seemed to hold out the hope of an early end to the war. The lot of the POWs improved as more and more of them were transferred into Chinese hands. They received new clothing and a more ample diet. The Chinese adopted a policy aimed at using and, if possible, at converting the prisoners to communism rather than allowing them to perish.

Not all the changes were for the better. During that summer and fall British and American doctors gradually found themselves crowded out by Chinese physicians who "exhibited a wide range of medical incompetence"; such doctors apparently held important posts because of their political reliability rather than medical expertise. The Chinese used some techniques, such as acupuncture, that were strange to their prisoners; immunized without the benefit of sterilized needles; and tried out such current Russian medical fads as implanting chicken livers beneath the skin. (A special high-protein diet brought quick recovery to many experimental subjects, who sloughed the implants. All then witnessed "another miracle of soviet medical science.")¹⁰

⁹Medical Corps, OSG, U.S. Army, 1 Dec 53, sub: Report of Conference With Repatriated P.O.W. Personnel, Document no. LD 1192897 F, Box 584, Accession no. 59A801, DIA Archives, Washington, D.C.

¹⁰Anderson et al., "Medical Experiences in POW Camps," pp. 121-22.

The mental state of the POWs reflected their changing fortunes at the hands of their captors. During the months of most severe privation their reactions ran a gamut from hostility to numbness and dogged survival. Acts of great altruism occurred in the camps, but so did acts of cruelty by the prisoners against one another. Because the men had begun to feel that any sickness would be fatal, the ill were sometimes forsaken when care might have saved them. Philip Deane cited GIs who stole their comrades' food or stripped the dying hours before death. He also took note of a "ginger-headed teen-ager" who, after surviving pneumonia and dysentery, volunteered for duty in the hut called the dysentery hospital. There he made sure that the patients at least got food, worked tirelessly to save them, and somehow remained cheerful, liked even by the guards, under conditions at which the imagination quails. "Letting a G.I. die in my hospital is something I won't do," he told Deane. They did die, of course, but less quickly than in the other "hospitals."¹¹

Under these stresses American soldiers often did not show up well by comparison with marines, or with men from the professional military units sent to Korea by other U.N. nations. Many soldiers had become POWs shortly after their arrival. Almost none had strong feelings of belonging to any unit. The enemy's practice of shuffling men back and forth from camp to camp and his deliberate policy of breaking down structures of loyalty and command among the prisoners increased each man's isolation. Escape from intolerable conditions through fantasy was common, aided by the widespread smoking of hemp (*Cannabis*). So was apathy. Cases were seen of men who apparently willed themselves to die. "The people who died," recalled a doctor, "would first become despondent, then would lie down or cover their heads with their blankets, then wanted ice water to drink with their food, eventually no food only water and eventually—death."¹²

Doctors found—as others had in dealing with similar cases in Japanese prison camps during World War II—that making the patient angry was one way to restore his will to live, and they coined the term "give-up-itis" as an irritant. The syndrome affected few healthy prisoners, and survivors of the camps emphasized that "every prisoner of war in Korea who died had suffered from malnutrition, exposure to cold, and continued harassment by the Communists. Contributing causes to the majority of deaths were prolonged cases of respiratory infection and diarrhea." Despair did not develop except in response to conditions that—one could very well argue—made dying a rational response though one the medics struggled against. There appears to be no reason to credit the postwar legend that prisoners in good condition died from mere lack of spirit. The 38-percent mortality among prisoners in North Korea was comparable to the 37.2 percent who died in Japanese prison camps. The chief determinant of mortality was how long the individual prisoner stayed in the hands of the enemy, which also followed World War II experience.¹³

¹¹Deane, *I Was a Captive in Korea*, p. 150.

¹²Medical Corps, OSG, 1 Dec 53, sub: Report of Conference With Repatriated P.O.W. Personnel, p. 24, DIA.

¹³Anderson et al., "Medical Experiences in POW Camps," p. 122. See also *Effects of Malnutrition and Other Hardships on the Mortality and Morbidity of Former United States Prisoners of War and*

Once camp conditions had improved and the Chinese had taken over the management of most prisoners (a process substantially complete by October 1951), the chief psychological pressure on POWs was the relentless program of indoctrination. How the prisoner was treated, how much cold or hunger he suffered, came to depend in considerable measure on his apparent progress in adopting the political outlook of his captors and in some cases supplying them with propaganda material. Under these conditions some prisoners became "progressives," who went along with their captors' desires and in a few cases demonstrated apparently sincere enthusiasm for their doctrines. At the other extreme a small number resisted every blandishment and threat, often paying with prolonged mistreatment or brutal torture. (Psychiatrists later noted that some of these men were admirable examples of mature, integrated personalities, while others were pathologically hostile to all authority, Communist or otherwise.) The great majority, in the phrase of the time, "played it cool"—gave what lip service they must and otherwise attempted to remain as inconspicuous as possible.

In sharp contrast to the supposed psychological subtlety of Chinese methods (a legend that spread with the popularity of stories about "brainwashing") most prisoners developed intense, though hidden, hostility toward their captors. The coercion, the hypocrisy into which they were forced in order to survive, and the sheer boredom of the endless lectures and self-criticism sessions all contributed to this, as did feelings of guilt over every concession they made to the interrogators. As in all prisons, status among the prisoners was the reverse of that among the jailers. Those whom the Chinese called progressives were "rats" to their fellows, and the "reactionaries" were admired, subject to some doubts about their sanity if they resisted to the point of endangering their lives.¹⁴

Overall, from the Communist viewpoint the program of indoctrination seems to have paid poor dividends, considering the investment of time and effort it entailed. Some propaganda advantages undoubtedly were won, but at the war's end only 347 U.N. prisoners, including 21 Americans, declined repatriation as against 22,000 North Koreans and Chinese. The Communist program also revealed something about the provincialism and naivete of the Chinese and North Koreans. They were convinced that they possessed a universal truth to which all people could be brought in time, yet even their communism consisted largely of parroting the works of Mao Tse-tung. Sophisticated GIs who knew something of Marx and Lenin found many of their indoctrinators easy to

Civilian Internees of World War II: An Appraisal of Current Information, House Document no. 296, 84th Cong., 2d sess., 12 January 1956, p. 33. The melodramatic postwar allegations against American POWs were refuted by Biderman, *March to Calumny*, passim, and "Dangers of Negative Patriotism," *Harvard Business Review* 40 (November–December 1963): 93–99. Cases of fatal depression among POWs were recorded during the Civil War. See Albert J. Glass, "Military Psychiatry in Korea," ch. 1, p. 12, CHA.

¹⁴Quoted words from Robert J. Lifton, "Home by Ship: Reaction Patterns of American Prisoners of War Repatriated From North Korea," *American Journal of Psychiatry* 110 (April 1954): 737. See also Henry A. Segal, "Observations on Prisoners of War Immediately Following Their Release," *Recent Advances in Medicine and Surgery*, 2:403–21; Edgar A. Schein, "Some Observations on the Chinese Indoctrination Program for Prisoners of War," Study for the Army Medical Service Graduate School, 1955, p. 33, file 383.6 Prisoners of War (Some Observations . . .) 1955, HRB.



DUSTING A CHINESE CAPTIVE

overcome in argument. Whether, by giving the POWs value in the eyes of their captors, the program prevented more suffering than it caused is a question that must remain unanswered.¹⁵

Communist Prisoners: The First Phase

The United States adhered to the principles of the Geneva Conventions, and its medical service was more expert and better supplied than those of the Communist powers. Because of this—and the proven ability of Chinese and North Korean prisoners to survive under difficult conditions—the latter, once safely incarcerated in prison camps, had considerably better chances than U.N. prisoners to maintain their life and health. The greatest initial medical problem resulted from the soldiers' poor condition before capture, neglect of their wounds and diseases by their own armies, and the overwhelming numbers who swamped the U.N. forces during September and October 1950. The physical condition of the average prisoner was that of the Asian peasant suffering from the complications of wartime deprivation and stress. As the Korean Communications Zone's Prisoner of War Command reported in 1953, the newly captured prisoner exhibited "debilitation, gastrointestinal anomalies, body vermin, [and]

¹⁵Hermes, *Truce Tent and Fighting Front*, p. 515.

respiratory infections. . . ." His ignorance of, and indifference to, Western notions of personal hygiene was vast. His most common illness was tuberculosis, arguably the chief plague of the Orient, which his military service often had aggravated.¹⁶

The condition of the wounded usually was deplorable, but especially so in 1950. Infection was rampant, maggots infested many wounds, dressings of leaves or paper intensified sepsis, and lack of immunization produced a fairly large number of tetanus cases. Men so seriously wounded and in physically poor condition imposed a heavy burden on Medical Service facilities. The first POWs were taken in July, but the great surge in numbers occurred after the Inchon landing. Because the South Korean government was unlikely to assure humanitarian treatment, the United States on 26 September took sole responsibility for custody of the POWs, though the South Korean Army's military policemen continued to make up the majority of prison guards. The prisoners numbered 224 in July; 2,688 in early September; 116,882 in October; and 127,459 in November.

Unprepared for this inundation, the United Nations Command improvised medical care for the POWs on the spot. The 3d Logistical Command originally was scheduled to take over base medical units in the X Corps area, but the corps headquarters retained control of its units in anticipation of the coming invasion of North Korea. As a result, the logistical command's Medical Section was left with little to do but run dispensaries and organize care for the POWs—a fortunate happenstance. As large numbers arrived at the enclosure near Inchon, the only medical aid came at first from two South Korean doctors, one of whom was a former prisoner of the Communists. With medical supplies hard to obtain even for U.N. troops, POWs at first had almost nothing. Capt. Gunnar Bohman, then serving with the 2d Engineer Special Brigade, was apparently the first American medical officer to assist the POWs. He secured additional space for them and saw to it that the injured had clean, DDT-dusted straw mats to lie upon. Then a surgical team from the 121st Evacuation Hospital contributed three days work, followed by two others from the 1st MASH. Meanwhile, hired South Korean doctors, nurses, and nurse's aides had begun work. Following a World War II practice, medical personnel among the POWs themselves were called upon to assist. American doctors continued to come on loan to work for a



MAJ. GEN. EDGAR ERSKINE HUME (right) and Surgeon General Bliss (center background) with prisoner of war at the 1st MASH

¹⁶Prisoner of War Command, Annual Report of Medical Service Activities, 1953, pp. 5–6, file 319.1–2 (Prisoner of War Command) Far East–1953, HRB. Quoted words on p. 5 of this source.

few days at a time, though two physicians from the 4th Field Hospital served from late October until all the patients had departed and the hospital had closed on 7 December.¹⁷

From reports by these officers a precise picture of the Inchon camp emerges. The four separate compounds were located a few miles southeast of the city. Headquarters for the medics was Compound 1, a former Japanese prison with stone buildings inside an enclosing wall; here was the main dispensary, the contagious ward, and the morgue. Other dispensaries were located in Compound 2, a tent city; in Compound 3, fenced-in factory buildings heavily damaged by shellfire and bombs; and in Compound 4, subterranean rooms and tunnels where the Japanese had stored ammunition. In these surroundings medics worked over men who were suffering from every type of gunshot and fragment wound and burn. The physical condition of the POWs was paradoxical. Patients were weak and run down, their wounds healed slowly, and many exhibited large abscesses that had no apparent cause. Yet they showed a tenacious grip on life.

Some 85,000 POWs passed through the Inchon camps, a river of dirty, lice-infested men plus about 250 women and 15 children. All had to be dusted and vaccinated. (Apparently, DDT killed the lice in about 149 out of 150 cases, leaving the resistant strains to multiply.) Diarrhea was common, and camp sanitation difficult to impose, all the more so because of the fluctuating population. Infectious hepatitis was common, and cases of erysipelas, a fulminating wound infection, turned up as well. There were forty-five cases of tetanus and three each of smallpox, typhus, meningitis, and relapsing fever. The expected high rates of tuberculosis were seen as well, and hardly a day passed without at least one death from the disease. A medical museum, the camp dispensaries reflected only too well the conditions of the whole Korean nation at the end of 1950—except that here the ills were treated.¹⁸

Many other hospitals received POWs who were on their way either to Inchon or to Pusan. Treating prisoners was for a time the chief duty of the 171st Evacuation Hospital at Taegu. In the lingering humid heat of the end of summer doctors and nurses confronted a ceaseless flow of pain-racked and fear-crazed patients whose language they did not speak, and whose time in the hospital was usually twenty-four hours or less. Work went on in tents pitched beside the hospital's quarters and in the four long wooden buildings of the teachers college. To convince the POWs that the operating room was not a torture chamber, hospital personnel hit on the device of returning postoperative cases to the tent from which they had come. A South Korean interpreter explained the dialogue that followed:

'What did they do to you?'

'They fixed my leg.'

'Are you sure you have a leg underneath that white rock [the cast]?'

'Of course I have a leg. I can feel it, can't I?'

¹⁷3d Logistical Command, Annual Report of Medical Service Activities, 1950, pp. 1–2, file 319.1–2 (3d Logistical Command) Far East–1950, HRB.

¹⁸4th Field Hospital, Annual Report of Medical Service Activities, 1950, Appendix on Medical



OPERATING ON A CHINESE PATIENT AT THE 64TH FIELD HOSPITAL

Convinced at last, POWs began asserting their right to be taken in the order of their arrival. When a worse-injured comrade went before them, some pouted like children. "This about face of the North Koreans," said a nurse, "was our most surprising contact with the enemy."¹⁹

The initial housing of POWs was wherever they could be put. Water was perpetually short in many of the makeshift prison pens; the prisoners were entirely innocent of notions of sanitation, as were their South Korean guards. The U.N. armies had outrun their own supply lines in many cases and, as a result, food for prisoners was often inadequate. Surveys turned up evidence of protein deficiency. Prisoners taken during the warm weather were unequipped for the cold, and surplus clothing had to be rustled up for them. Some evidence exists that the tragedy of the U.N. prisoners during the North Korean retreat was repeated in milder form among Communist prisoners during the withdrawal of the U.N. forces in the winter of 1950. With the onset of colder weather and the movement of large groups of POWs from the enclosures at Inchon and

Activities of the POW Inclosure, Inchon, Korea, 21 October–7 December 1950, file 319.1–2 (4th Field Hospital) Far East–1950, HRB.

¹⁹Quoted words from Surgeon's Circular Letter 6, no. 2, Medical Section, FEC, 1 Feb 51, pp. 24–25, file 461 (Circular Letters) FEC, HRB. See also 8086th Army Unit, Military History Detachment, "Logistical Support to Prisoners of War," pp. 2, 5, 32, Ms no. 8–5.1A AA.C, RG 319, MMHB.

Pyongyang to Pusan, "the condition [with respect to housing, heating, and clothing] became acute," reported the Eighth Army surgeon. "There were no . . . facilities available for heating tents."²⁰

Around Pusan developed the first of the huge complexes of prisoner-of-war camps whose management was to burden and bedevil the United Nations Command for the rest of the war. What was to become a vast medical establishment began unobtrusively about 1 August as a dispensary of the 8054th Evacuation Hospital, which served a small number of prisoners captured during the early fighting. In mid-September the 1st Prisoner of War Field Hospital (Provisional) was set up by the Eighth Army, still drawing its personnel on detached service from the 8054th. By the end of the month, as U.N. casualties decreased, Hospitalization Unit 1 of the 64th Field Hospital became available to work with the burgeoning prisoner population. The unit, which had aided both U.N. and prisoner-of-war wounded at the Pusan Middle Girls School, now set up a prisoner-of-war hospital in buildings vacated by the Eighth Army, Rear, headquarters. Within a few days over 2,000 patients were admitted. In mid-October the 64th turned over its wards to the 14th Field Hospital (Provisional) and moved to Taejon to rejoin the rest of its unit. The 64th, however, was by no means finished with prisoner-of-war affairs.²¹

In December the 3d Field Hospital replaced the 1st Prisoner of War Hospital. The commander of the 14th Field Hospital assumed command of both, forming what was in fact a large general hospital with the double mission of treating prisoner-of-war casualties direct from the line and caring for injured and sick among the existing body of inmates. In combination, the units may well have formed the largest hospital in the world. A visitor in late 1950 reported some 3,000 patients housed in tents. By March 1951 the patient census had reached 10,800, before subsiding to a monthly average of 7,500 to 8,000. At the high point in March, according to an Australian medical officer, about half the patients were surgical cases and half medical; about 2,000 had orthopedic injuries, chiefly gunshot wounds of the limbs; and several hundred, at the end of the winter's fighting, were suffering from frostbite with gangrene.²²

Here, as at Inchon, the wards were a "walking pathological museum" with every sort of wound; with a throng of tuberculosis patients and cold weather cases of lobar pneumonia; and with exotic cases, including four lepers. Yet in December 1950 a civilian consultant found that the hospital grounds were clean despite the difficulty of compelling inmates to use "the largest latrine in the world . . . an imposing open affair containing over 200 holes covered with wooden lids." A loudspeaker system insistently broadcast simple rules of hygiene in the Korean tongue. In stark contrast was a South Korean hospital in

²⁰EUSAK, Annual Report of Medical Service Activities, 1950, pp. 43, 47, file 319.1-2 (EUSAK) Far East-1950, HRB. Quoted words on p. 43 of this source.

²¹3d and 64th Field Hospitals, Annual Reports of Medical Service Activities, 1950, pp. 1-2 and p. 7, respectively, files 319.1-2 (3d Field Hospital) and (64th Field Hospital) Far East-1950, HRB.

²²N. M. Kater, "Some Experiences in a Korean Prisoner-of-War Camp Hospital," *Medical Journal of Australia* 1 (March 1953): 409; 3d and 14th Field Hospitals, Annual Report of Medical Service Activities, 1951, p. 1, file 319.1-2 (3d and 14th Field Hospitals) Far East-1951, HRB.



MEDIC ADMINISTERING BLOOD TO CHINESE PATIENT ON KOJE

downtown Pusan. Here wounded lay on the floor on thin rice mats. Many were naked. The hospital stank of rotting straw, urine, feces, and dead air, "almost something out of Hogarth. . . . Our enemies were receiving much better care at our hands than were our allies at the hands of their own people."²³

Outside the hospital, general conditions in the Pusan prison enclosures could be termed good only by comparison with those endured by U.N. prisoners in North Korea. The concentration of the POWs had evident dangers as well as advantages. With the Chinese advancing and U.N. forces anticipating the possibility of being pushed into the sea, prisoners did not enjoy a very high priority for any sort of supplies. Sanitation was the big loser in the camps. Dysentery and respiratory diseases were rife. Space was inadequate, heating and housing deficient, and the water supply at Camp No. 3, with a population of 39,370, was only one-half gallon a day per capita as against an estimated minimum requirement of 10 gallons. This was an extreme case—Camp No. 1, the best off, averaged 13 gallons a day, and none of the others had less than two—but it pointed to a fundamental deficiency. Bathing, washing, and laundry were not to

²³Rpt, Howard D. Fabing, M.D., 30 Dec 50, sub: Recent Trip to Far East Command, pp. 6–7, file 730 Neuropsychiatry (Consultants Visits) Far East 1950–51, HRB. The reference is to Hogarth's portrayals of the underside of life in eighteenth-century London.

be thought of among a vast population of lice-ridden men (and some women) whose vermin now were often DDT-resistant. Tents were unheated; both tents and stoves were in short supply; and only construction of mud huts by the prisoners themselves alleviated overcrowding.

Improvement was slow, a matter of expedients. Surplus clothing finally met the need created by cold weather. Bedding was simply rice bags placed on the ground, and blankets were furnished, two for each prisoner and three for each hospital patient. Sewage was managed through use of pit or pail latrines. Despite outbreaks of dysentery, however, no serious epidemics occurred. Like the U.N. forces, the prisoner-of-war camps squeaked past the crisis period of the winter, and during the following year satisfactory medical control was established.²⁴

Meanwhile, on 28 January 1951 the first POWs arrived on mountainous Koje (*Map 7*), an island off the southwest coast in the Korea Strait. The result of a hurried decision forced by the pressure of an advancing enemy, the move presented serious logistical and medical problems. The command structure on Koje was still more fortuitous than that which had developed at the Inchon enclosure. The 3d Logistical Command bucked responsibility down to the 60th General Depot, which had lost its function of supplying X Corps when the latter was absorbed by Eighth Army during late December. Actual planning fell to a physician and a Medical Service Corps officer from the command. As the first party of 2,500 POWs arrived in a cold, rainswept region enclosed by almost treeless hills, frantic improvisations began to house, guard and care for them. At the end of January only a dispensary existed, and any who became seriously ill had to be evacuated on pitching LCTs, or similar light landing craft, back to the mainland. During February incessant rain and "extremely poor living conditions" helped to ensure that such evacuations would be frequent.²⁵

Gradually the medical staff on Koje increased, drawing personnel from the 3d and 14th Field Hospitals at Pusan. For a time the medical unit on the island was called the 3d Field Hospital Annex. The first true hospital, wrecked by a typhoon, was rebuilt and reopened in tents during March. It rapidly expanded to twenty-three hundred beds and by summer reached three thousand. As on the mainland, South Korean civilians and prisoners helped to staff it. As more supplies became available, all but the most serious cases were retained. By the end of April the 64th Field Hospital, newly assigned to help with the POWs, began to arrive on Koje from Japan. The provisional hospital now was phased out. The depot command became the United Nations Prisoner of War Camp No. 1. As Army engineers developed the camps into livable sites and the guards organized the POWs for many purposes—to clean latrines, gather kelp for food, construct adobe huts, and make furniture to fill them—the sordid and miserable early phase of life on the island ended.

²⁴EUSAK and 3d Field Hospital, Annual Reports of Medical Service Activities, 1950, pp. 42–44 and p. 4, respectively, HRB. See also FEC, Annual Report of Medical Service Activities, 1950, p. 50, file 319.1–2 (FEC) Far East–1950, HRB.

²⁵United Nations Prisoner of War Camp Number 1 (Headquarters, Military Police Group, 8137th Army Unit), Annual Report of Medical Service Activities, 1951, pp. 4–5, file 319.1–2 (U.N. Prisoner of War Camp No. 1) Far East–1951, HRB. Quotation on p. 5.



MAP 7

Now POWs were better fed, housed, clothed, and cared for. After much experimentation, lindane proved effective against the resistant lice, and during December 1951 infestation declined both on the mainland and on Kojé to 3 percent or less. Improved sanitation, including engineer-built sewer lines, helped to control enteric diseases after a major epidemic had swept through the camps in the spring. Systematic immunization of newcomers ended the threat of smallpox. Typhoid was a useful index to the general health situation: By the summer of 1951 intestinal perforation caused by the disease had dropped spectacularly, probably because of immunization.

In the course of the year teams from the United States Fleet Epidemic Control Unit, the Armed Forces Epidemiological Board, and the Office of the Surgeon General visited Kojé to study dysentery and tuberculosis. Dentists among the prisoners were allowed to work under the supervision of an American dental officer. Both on the island and on the mainland, hospitals went beyond the treatment of existing trauma to perform reconstructive and plastic surgery. A shop for manufacturing artificial limbs for POWs was set up at Pusan. Though the endemic diseases proved tenacious and hard to tackle, progress was recorded in almost every phase of preventive and clinical medicine.²⁶

The Riots and After

Improved control of disease did not, unfortunately, imply adequate control of the POWs themselves. In the prison camps of North Korea the Chinese were attempting to wage revolutionary war by converting their captives to communism. In the camps near Pusan and on Kojé the United Nations Command worked in another set of cultural blinders created by "current directives, the articles of the Geneva Convention, and . . . the highest principles of medical ethics and humanitarian policies." Typically, a commander of the 3d and 14th Field Hospitals grossly misinterpreted the happiness of many POWs when they discovered they were not to be tortured and killed, concluding that "once these patients realize that the effort here is no longer toward destruction but rather toward reconstruction, they become very cooperative. . . . The patients in general are quite grateful and many . . . have become quite valuable as helpers due to their cooperative attitude."²⁷

In itself decent treatment for captives was not a fatuous policy. But apparently too little consideration was given to the active and committed Communists among the prisoners, who assumed that they were still part of the armed struggle, with a special mission to foment trouble behind enemy lines. Even alert hospital personnel were frustrated by their patients' cleverness and overwhelm-

²⁶64th Field Hospital, Annual Report of Medical Service Activities, 1951, pp. 7-8, file 319.1-2 (64th Field Hospital) Far East-1951, HRB. See also EUSAK and FEC, Annual Reports of Medical Service Activities, 1951, pp. 25-26, 57-59 and pp. 21-22, 27-28, respectively, files 319.1-2 (EUSAK) and (FEC) Far East-1951, HRB.

²⁷First quotation from 8086th Army Unit, "Logistical Support to Prisoners of War," p. 101, RG 319, MMHB. Second quotation from Surgeon's Circular Letter 6, no. 6, Medical Section, FEC, 1 Jun 51, file 461 (Circular Letters) FEC, HRB.



RAIDING A PRISONER-OF-WAR COMPOUND ON KOJE

ing numbers. As the impasse developed over prisoner exchange and the truce talks faltered, the Communist high command seemingly pursued a deliberate policy of encouraging disorder in the prison camps to distract world attention from the very large number of their soldiers who had decided not to return home. Sabotage extended even to deliberate blocking of the newly installed sewer lines.

American and South Korean Army guards were insufficient in number, often poorly trained, and occasionally trigger-happy. Food supplies from the South Korean government were at best erratic. These pressures combined with the work of agitators to heighten tension in the crowded camps, giving Red leaders real as well as imagined grievances to exploit. During late 1951 and early 1952, incidents of prisoner-of-war insubordination grew in number and severity. By mid-1952 some two hundred outbreaks, including riots and some deaths, had occurred.²⁸

²⁸EUSAK, Report of ETMD, March 1952, p. 34, file 350.05 (EUSAK) 1952, HRB, Staff Study, 2d Logistical Command, 31 May 1952, sub: Factual Summary of Situation in United Nations Prisoner of War Camp Number 1, Koje-do, Korea, and Encl 11, Ltr, Commanding General, 2d Logistical Command, to Commanding General, EUSAK, 18 Sep 51, sub: Security of Prisoners of War, in vol. 2 of 2d Logistical Command Monthly Command Report, file LOGC-2 (Supporting Documents, 2d Logistical Command, May 52), Box 6189 (Nonorganic Units, 2d Logistical Command, LOGC-2, Narrative w/vols. 2 and 3, May 52), Entry 429, RG 407, MMFB.

The prison hospitals were especially vulnerable to disorder, for a variety of reasons. Obligated to deal with some eighty-eight hundred occupied beds, their personnel were too few, most were unarmed, and some apparently were hobbled in meeting security needs by their professional ethics and humanitarian ideology. The facilities were compelled to employ POWs as doctors, nurses, and ward attendants to eke out their staffs of uniformed Americans and South Korean civilians—a continuation of a policy that had worked well during World War II. Once inside the hospital compounds, POWs found themselves in a situation where “security . . . was practically non-existent [*sic*].” Tough and determined men found the conditions a pushover. On Koje the 64th Field Hospital became a Communist communications center, as its commander admitted. At Pusan the end result was what 1st Lt. Stanley Weintraub, a Medical Service Corps officer, called “war in the wards.”²⁹

A young admissions officer, Weintraub recorded in his diary the “minuscule confrontation between Communist and Western minds” that he saw as the essence of the bizarre happening. By the spring of 1952 the combined 3d and 14th Field Hospitals formed the center of a complex that not only provided definitive care for POWs but also, after a medical examination, funneled newly arrived prisoners to the camps offshore. A mammoth general hospital despite its official designation, the facility consisted of a two-storied white-stuccoed school building enclosed by the wards, a “dreary collection of huts and tents” in barbed-wire compounds. Other compounds housed the healthy POWs who worked in the hospital. Beyond stretched a vista of “dusty villages and fecally aromatic rice paddies.” Fierce ideological passions seethed among a patient population that included Reds, impressed South Koreans, and Chinese who had fought for Chiang Kai-shek. Communist kangaroo courts operated freely. At daybreak, corpses left at the compound gates frequently exhibited signs of execution by blunt instrument or hanging.³⁰

Throughout April 1952 the United Nations Command was at work in the camps, screening prisoners to determine who would forcibly resist repatriation and moving those who said they would away from Koje. On the island the 64th Field Hospital was in the thick of things, treating tortured prisoners who had survived the kangaroo courts. Some prisoners were not so fortunate; tied down and beaten along the back from neck to lower legs with tent poles, which crushed the subcutaneous tissues, they died from pulmonary fatty embolism four to eight hours later.

As events moved to a climax in May 1952 the Communists kidnaped Brig. Gen. Francis T. Dodd, the camp commandant, at the gate of Compound 76, directly in front of the hospital. Surrounded by some eighty thousand hostile prisoners and connected to the headquarters by one narrow road between the compounds, the 64th Field Hospital evacuated its female nurses. For three days

²⁹First quotation from 64th Field Hospital, Annual Report of Medical Service Activities, 1951, p. 22, HRB. Second quotation from title of Stanley Weintraub's *The War in the Wards: Korea's Unknown Battle in a Prisoner-of-War Hospital Camp* (New York: Doubleday, 1964).

³⁰Weintraub, *War in the Wards*. First quotation on p. 179; second, third, and fourth quotations on p. 8.

active treatment of POWs perforce ended, though food and medications continued to be distributed daily for their use. The situation grew worse as Dodd's successor, Brig. Gen. Charles F. Colson, won his predecessor's release by giving the POWs a statement that proved to be a propaganda godsend for the Communists. (For this action both officers were broken to the rank of colonel.)

Then Maj. Gen. Haydon L. Boatner was appointed commandant. Paratroopers of the 187th Regimental Combat Team, flown in from Japan, reasserted control. Striking prisoner-of-war hospital personnel were first denied food, then removed forcibly from the positions they had exploited and replaced by South Korean civilians. Their lives threatened, the civilians went "over the hill," compelling American military personnel to feed and care for 1,900 patients and to stand duty twenty-four hours a day in order to do so. Then the paratroopers invaded and broke up the most rebellious compound by force. The hospital received 122 wounded and 41 dead POWs. Eleven Americans suffered spear thrusts and 1 died from a misaimed concussion grenade.³¹

During the standoff many wounded POWs from Koje overflowed the 64th Field Hospital and were sent on to the 3d and 14th Field Hospitals at Pusan. Violence also broke out on the mainland. On 11 May, when the military police officer who commanded Compound 10—the pens surrounding the 3d and 14th facility—announced that nonpatients would be separated from patients and screened, three compounds refused to obey, and the confrontation was on. Mobs of tuberculosis patients and amputees on crutches marched and shouted slogans under the leadership of Red honchos. Notable among the leaders were prisoner-of-war attendants and doctors, regardless of the fact that most of the latter seemed "as little committed to Communism as they are to medicine." American doctors were in a strange situation, confronted by patients who were also enemies, uncertain whether to halt food and treatment in hopes of restoring order or to follow their ingrained professional instincts to minimize suffering and loss of life despite all provocations. As troops gathered to suppress the outbreaks for good, Weintraub one night recorded a scene that unforgettably froze this strange moment in the war:

As we jeep along, the tangled barbed wire and squat ROK guard towers twist the moonlight into strange shadows. The Korean tower sentries now stand silently in the cool air, now thump their boots on the wooden platforms to keep warm—their syncopated drum taps are the only sounds in the night to compare with the droning vehicle motors. We pass tanks and jeeps on the slow pace of regular patrol, half-tracks with 50-caliber machine guns perched on rocky prominences, pointing their 'quad-fifties' toward the quiet hospital.³²

³¹64th Field Hospital, Annual Report of Medical Service Activities, 1952, pp. 1–7, file 319.1–2 (64th Field Hospital) Far East–1952, HRB; 187th Airborne Regimental Combat Team Command Report, June 1952, file 311–INF (187) (Command Report, 187th Airborne Regimental Combat Team, 11th Airborne Div, Jun 52), Box 3460 (11th Airborne Div, 311–INF (187), Jun 52), and 2d Logistical Command Monthly Command Report, May 1952, file LOGC–2 (Command Report, 2d Logistical Command, May 52), Box 6188 (Nonorganic Units, 2d Logistical Command, LOGC–2, Narrative w/vol. 1, May 52), both in Entry 429, RG 407, MMFB. See also Hermes, *Truce Tent and Fighting Front*, pp. 243–55; Goulden, *Korea*, pp. 596–98.

³²Weintraub, *War in the Wards*. First quotation on p. 58; second quotation on p. 71.

The days were raucous. Loudspeakers blared at the prisoners, urging submission. Tanks rumbled up to the wire, planes buzzed the compound, and infantrymen ostentatiously practiced with flamethrowers in full view of the prisoners. Meanwhile, POWs defiantly scaled the roofs of their barracks and waved red flags dyed in the blood of executed anti-Communists. There was a brief lull while the International Red Cross interviewed prisoner representatives. One compound submitted peacefully, but the others remained defiant. On 20 May infantrymen cut the wire and invaded with bayonets, tear gas, and concussion grenades. POWs fought back with makeshift javelins, honed from aluminum litter poles or whittled from tent supports; with knives; and with flails of barbed wire. Almost unbelievable episodes occurred:

A bilateral amputee crawls out of his [tear] gas-filled hut on his stumps, leans against the side of his hut for support, and aims a sharpened litter pole at a passing GI, who sees him just in time. Clobbered over the head with a rifle butt, the PW tumbles into a muddy drainage ditch, the spear bouncing in after him. GI medics following behind pull him out, but leave the spear stuck crazily in the ditch bank.³³

Amid the wrecked huts, the crackle of burning red flags and propaganda banners, and the fumes of tear gas, hospital personnel began the task of policing up, resuming treatments that had been interrupted in some cases for a month or more. Only one prisoner was dead and twenty-nine wounded, a tribute to the steadiness of the infantrymen who fired no shots. Screening proceeded. Hardcore Communists were shipped to Kojé; anti-Communists were segregated and protected. For one loss there was no real answer, however. The rioters had destroyed most of their own records, and names, X-rays, and case histories had disappeared forever.³⁴

The wonderful tenacity and all but indestructible toughness of their soldiers had yielded the Communist states important propaganda advantages, to say nothing of influencing military operations by diverting American combat troops from other duties. The lax administrative practices of the hospitals, founded in an attitude of mind that exalted humanitarian and professional considerations to the neglect of security, had contributed to the severity of the outbreaks. These were the harsh reverse sides of policies from which few Americans of the time would have dissented—decent treatment for sick and wounded POWs, and refusal to compel anti-Communist prisoners to return to their homelands against their will. In the event, a fifth of all prisoners faced acute personal danger to refuse repatriation, and the U.N. forces incurred tens of thousands of additional casualties to maintain the principle that allowed them to do so.³⁵

³³Ibid., p. 164.

³⁴Ibid., p. 166; 3d and 14th Field Hospitals, Annual Report of Medical Service Activities, 1952, p. 6, file 319.1-2 (3d and 14th Field Hospitals) Far East-1952, HRB; 2d Logistical Command Monthly Command Report, May 1952, pp. 56-61, RG 407, MMFB; Haydon L. Boatner, "How I Crushed the Reds on Kojé Island," *War Stories* (Summer 1964): especially 21; Hermes, *Truce Tent and Fighting Front*, pp. 236 and 255-57.

³⁵8086th Army Unit, "Logistical Support to Prisoners of War," pp. 89-90, RG 319, MMHB; Hermes, *Truce Tent and Fighting Front*, p. 515.



REMOVING WOUNDED POWs AFTER THE KOJE RIOTS

With order restored, the hospitals were transferred in August 1952 to the control of the Korean Communications Zone. The 2d Logistical Command handed over its responsibilities to the Prisoner of War Command. Some features of the old regime continued in the new. Medical training was given as before to POWs whose assistance was still essential for the understaffed hospitals, and American doctors held regular sick call, aided by prisoner-of-war attendants and doctors. A few post-riot reforms, however, were implemented. The prisoner population was broken up into smaller enclosures. This in turn required each compound to have a holding ward where short-term cases could be treated in a manner similar to infirmaries. But POWs had tenacious diseases and injuries requiring long-term treatment so that large numbers still had to be hospitalized, a continuing danger to those who cared for them. Tuberculosis remained the most important cause of lengthy hospitalization, and medical personnel made slow progress, treating moderately advanced cases with bed rest and additional diet, severe cases with antibiotics. Dysentery remained a problem, a persistent cause of a large, constantly fluctuating patient census.³⁶

³⁶EUSAK and KCOMZ, Annual Reports of Medical Service Activities, 1952, p. 12 of annex 4 and p. 3 of encl. 1, respectively, files 319.1-2 (EUSAK) and (KCOMZ) Far East-1952; KCOMZ, Report of ETMD, November 1952, p. 4, file 350.05 (KCOMZ) 1952. All in HRB.

From the beginning, nutrition had posed special difficulties in the camps. In all probability the POWs' food was insufficient during the crises of late 1950 and early 1951. Thereafter, an improved diet may have contributed to the unrest, not only because the more nutritious food made the POWs physically better able to resist but also because the organization of POWs for food gathering, as for other purposes, enhanced the internal autonomy of the camps. Supplies purchased largely from oriental sources gave prisoners a diet that was both familiar and, according to early nutritional surveys, adequate—between 2,200 and 2,850 calories a day during 1951, for example. The survey teams that visited individual messes to determine whether food rations actually were reaching the prisoners concluded that they were. The POWs were, of course, full of worms and bore in their bodies all the consequences of a lifetime of inadequate diet. Continuing high sick call rates were attributed in part to malingering and in part to general debility.

In early 1953, however, the International Red Cross complained that the POWs were not receiving sufficient food. General Mark Clark requested a nutrition survey team to investigate. Meanwhile, persistent press reports of malnutrition among soldiers of the Republic of Korea (ROK) Army had made a reexamination of their rations desirable as well. As a result, the surgeon general dispatched Col. H. D. Sandstead and Lt. Col. Carl J. Koehn to survey nutrition among prisoners, the ROK Army, and the Korean Service Corps. In contrast to earlier surveys, Sandstead and Koehn did not confine themselves to caloric estimates but thoroughly examined the questions of vitamin and protein intake as well. They concluded that the POWs were in fair nutritional state, with the North Koreans in better condition than the Chinese. Principal deficiencies were in vitamins A, B2, and C. They recommended treatment with brewer's yeast, replacement of lima by soybeans in the ration, and substitution of canned beef and pork for dried fish and of green for root vegetables. Monitoring by the Medical Service evidently was less than rigorous, though the deficiencies may well have resulted in large measure from the prisoners' own dietary preferences.³⁷

By March 1953 the exchange of sick and wounded prisoners was approaching, but the POWs' resistance continued and intensified. The increasing danger once again caused the removal in February 1953 of all American female nurses from the wards of the 64th Field Hospital and their replacement by corpsmen and Korean nurses. By early March the situation was sufficiently perilous that a "buddy" system had to be set up in the hospital compounds, medical personnel

³⁷EUSAK, Annual Report of Medical Service Activities, 1951, p. 69; KCOMZ, Report of ETMD, September 1951, p. 24, file 350.05 (KCOMZ) 1951; KCOMZ and USAFFE, Annual Reports of Medical Service Activities, 1953, p. 9 and p. 68, respectively, files 319.1-2 (KCOMZ) and (USAFFE) Far East-1953. All in HRB. See also 8086th Army Unit, "Logistical Support to Prisoners of War," pp. 18-19, 23-24, 27, 31, RG 319, MMFB. Menus for POW patients can be found attached to 64th Field Hospital, Annual Report of Medical Service Activities, 1951, HRB. For survey report, see Summary of Significant Findings and Recommendations of the Report to the Chief Surgeon, United States Army Forces, Far East, 20 Jul 53, sub: Report of Nutrition Survey of ROKA, KSC, and PsW, attached to DF, Col R. G. Prentiss, Jr., MC, Executive Officer, OSG, to Col Arthur P. Long, MC, Acting Chief, Preventive Medicine Division, OSG, 24 Aug 1953, and to related correspondence on same subject, file 720.1 (Korea) F, 1953, Box 54, Accession no. 56A-179, RG 112, WNRC.

doubling up to perform all tasks while roving patrols circulated. The increasing disorder was related to the crisis in the truce talks which signaled the approaching end of the war. To medical personnel the trouble underlined their need for still more men at the habitually understaffed hospitals. But the prisoner exchange and the phaseout of the 64th occurred before higher headquarters could act on the hospital's request for additional staffing.³⁸

All in all, the experience with the Communist POWs was a remarkable one, without real precedent in American military history. Accustomed to subdued, easily controlled enemy prisoners during World War II, Americans of the 2d Logistical Command and its successor found themselves facing organized, determined men, ideologically motivated, who continued the war as prisoners with scant regard for the pieties of the Geneva Conventions. Of all Americans, the medical personnel were probably the most thoroughly imbued with the spirit represented by the accords and the least ready to meet the requirements of the situation. Hospitals faced with rebellion among their patients learned to their cost that when security failed treatment ended as well.

Yet the riots tended to conceal the fundamental success of the policy of good treatment. Whatever their basic motivation in refusing repatriation, it is difficult to believe that starved or abused POWs would have chosen in so many cases not to return home. The United Nations Command followed a policy dictated by American and West European cultural norms and by international obligations emanating from membership in the United Nations and from the moral authority of the Geneva Conventions. Medics followed, even more than policy or orders, the imperatives of their professional consciences. Even with the riots, the results tended to vindicate the practical value of those ideals. One could reasonably argue that the United Nations Command won its strangest victory behind its own lines.

The Refugee Problem

Immensely greater in numbers than the prisoners were the refugees, the second element in the huge medical problem that developed behind the battlefield. According to available estimates, which varied in their totals, about one-seventh of the total population of South Korea were refugees at one time or another during the fighting. Refugees came in two great waves (*see Map 8*), following the initial invasion and the Chinese intervention, but the condition of homelessness and dependence became chronic for many whose villages were destroyed, or else occupied by the fighting forces during the long period of static warfare. Both victims and carriers of disease, subject to epidemics and in need of everything—a military, social, and medical problem of the first importance—the refugees also became the objects of a program of civil assistance through the United Nations Command that grew to embrace every aspect of reconstruction in Korea.

³⁸8086th Army Unit, "Logistical Support to Prisoners of War," p. 108, RG 319, MMFB.



MAP 8

In the dark days of July 1950 U.N. commanders viewed refugees largely as a grave military problem. North Korean soldiers covered their uniforms with the traditional white garb of the Korean peasant and mingled with the fleeing columns. But the refugees were too many for U.N. troops to screen and search. One woman who appeared to be pregnant was found to be carrying a radio under her clothing. Men were observed changing from civil to North Korean military garb and back again. Even innocent refugees obstructed roads and impeded troop movements. As they crowded into the Pusan Perimeter, both medical and supply problems confronted the United Nations Command. To protect its troops and to prevent unrest, the refugees had to be fed, instructed in basic sanitation, immunized, and provided care when sick. The emergency phase of civil assistance had begun.³⁹

First to be tasked with the problem, about 1 August, was SCAP's Public Health and Welfare Section under General Sams. Sams arrived in Pusan with four members of his staff and began to survey the needs of the people crowded into the Pusan Perimeter. He assigned an advisory team to the South Korean government's central relief committee and others to advise the two surviving provincial governments at Pusan and Taegu. The Americans' job was essentially to get supplies, to ensure their proper distribution, and to give the benefit of the professional knowledge and experience they had gained in Japan to the Korean authorities. Problems were severe. Some three hundred thousand refugees were then living in the river bottoms in summer heat among multiplying insects and impure water. Cases of typhus, typhoid, and diphtheria had appeared among them. Civilian hospitals no longer operated in Pusan, for the ROK Army had seized the existing facilities.

A mass program of immunization, delousing, and sanitation began. In the large refugee camps, teams were organized among the inmates to police the grounds, to clean the wells, to chlorinate water supplies, and to instruct their compatriots in principles of basic hygiene, which they had newly learned themselves. Volunteer teams fanned out to the villages, spreading the word. Millions received shots. An intensive DDT dusting program took aim at the vectors of the Korean summer. By good fortune all the water supply plants in the Pusan Perimeter, except three in the North Kyongsang Province, continued to function. South Korean health and sanitation officials cooperated with the effort. Despite the usual difficulties in persuading or forcing people to change the habits of a lifetime—peasants still tended to regard any unoccupied square yard of ground as a proper spot for defecation—sufficient control was achieved to prevent the outbreak of epidemics. Under the conditions of the perimeter, that was a remarkable accomplishment.⁴⁰

³⁹1st Cavalry Division War Diary, 24 Jul 50, file 901 (War Diary, 1st Cav Div, 25 Jun-Jul 50), Box 4405 (1st Cav Div War Diary w/G-2 and G-3 Sections, Jul 50), Entry 429, RG 407, MMFB; Military History Section, FEC, "History of the Korean War," vol. 3, pt. 5, "Civil Affairs/Civil Assistance Problems," pp. 27-28, Ms No. 8.5-1A AA.F, RG 319, MMHB.

⁴⁰FEC, Annual Report of Medical Service Activities, 1951, pp. 177-81; extract from Presentation, Brig Gen Crawford F. Sams, MC, to Brig Gen Earle Standlee, MC, OSD, et al., 8 Jun 51, sub: Disease and Hospital Conditions in Korea, HSF (Sams-1951). Both in HRB.

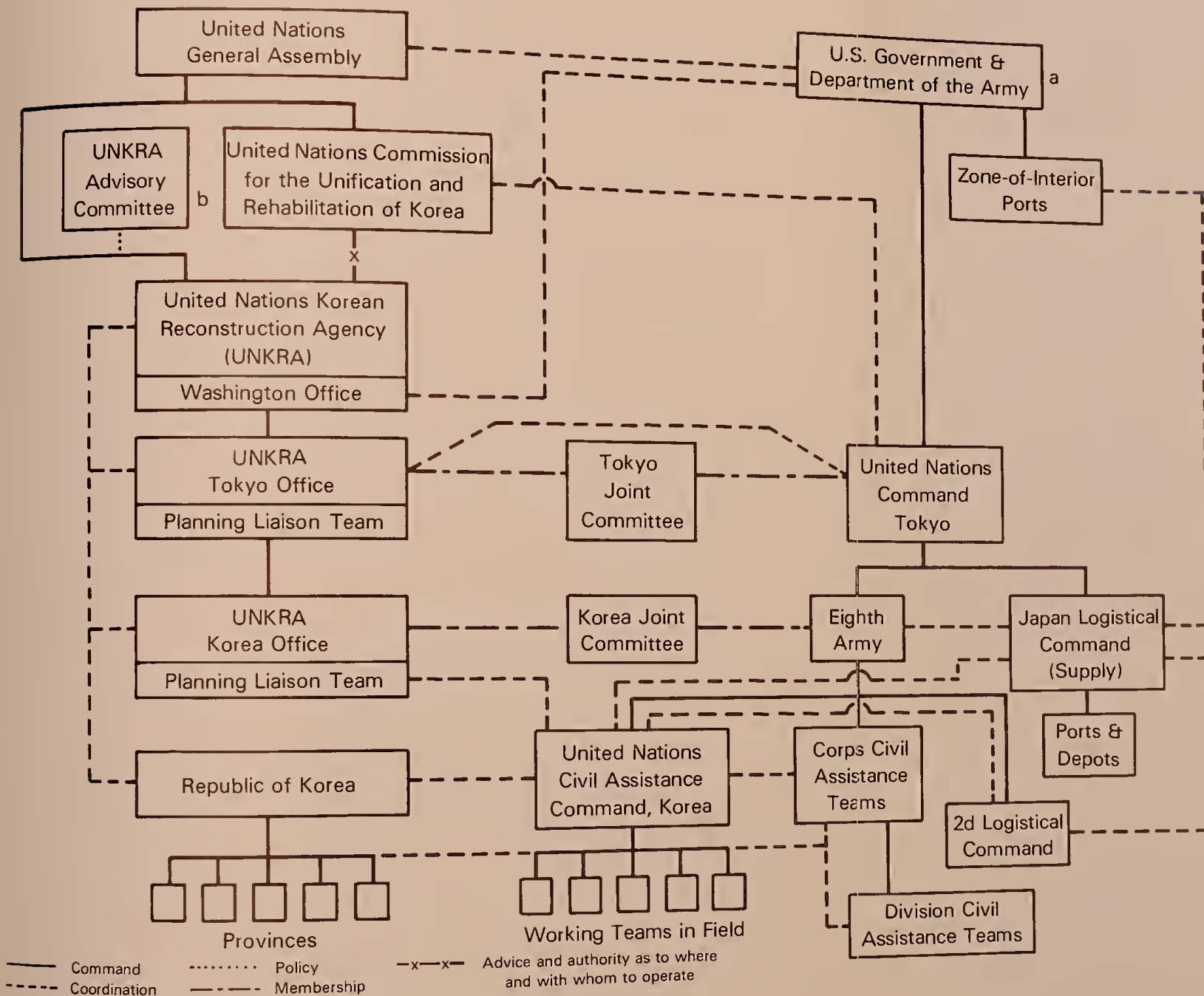


KOREAN REFUGEES NEAR CHUNJU

Organization of the effort went apace. Arriving in Seoul at the end of September, Sams' groups found Colonel Mollohan, Sams' Public Health and Welfare Section deputy, awaiting them. Two U.N. civilians from the International Relief Organization joined the team. Though MacArthur's G-4 (logistics) section still coordinated various aspects of the program, the Eighth Army headquarters had responsibility for organizing the work and, in consequence, set up a Civil Assistance Section. For the time being the personnel remained the same, drawn mostly from Sams' staff. Funds came from various sources, including Economic Cooperation Administration money originally intended for economic development. Civil assistance teams advanced with the fighting line. Under MacArthur's orders, they moved into North Korea to provide similar help to the people there, launching the usual immunization and delousing programs.

The growing importance of the work caused the Eighth Army to organize a field operating unit called Headquarters, Civil Assistance, Eighth Army. Meantime, another bureaucracy began to develop under the United Nations Commission for the Unification and Rehabilitation of Korea (*Chart 2*) and its executive arm, the United Nations Korean Reconstruction Agency (UNKRA). UNKRA loaned personnel and experts to the United Nations Command and offered policy advice to the South Korean government. Advisory teams took on an international flavor. General Sams noted on 18 December that "at present we have Americans, British, Dutch, Norwegians, Peruvians, Swedes and

CHART 2—ORGANIZATION OF THE KOREAN CIVIL ASSISTANCE PROGRAM, JUNE 1952

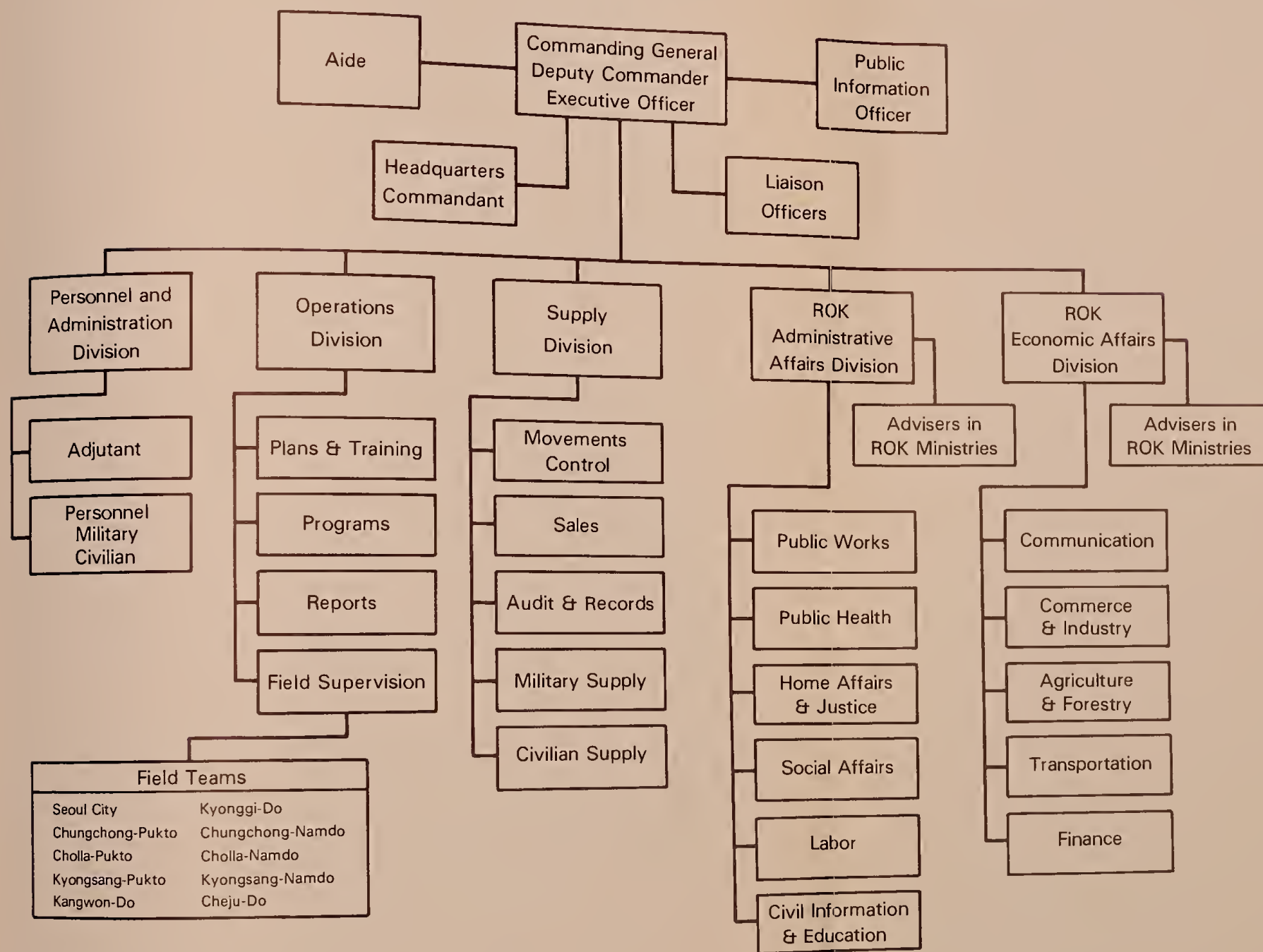


^a Unified Command.

^b Located at the United Nations.

Source: G-5, Headquarters, Far East Command and United Nations Command, *United Nations Civil Affairs Activities in Korea*, June 1952, p. x, LIB.

CHART 3—ORGANIZATION OF THE UNITED NATIONS CIVIL ASSISTANCE COMMAND, KOREA, NOVEMBER 1952



Source: G-5, Headquarters, Far East Command and United Nations Command, *United Nations Civil Affairs Activities in Korea*, November 1952, p. ix, LIB.

Canadians which is, you will agree, quite a hodgepodge. . . ."⁴¹ Though military personnel under Colonel Molloy had gone into Inchon, worldwide recruitment for civilian public health experts continued, and substantial civilian involvement in the work became the rule, despite overall military control.

Stimulated by the influx of new personnel, both military and civilian, civil assistance offices multiplied to cover every province by the end of the year, except the extreme southern one of Cholla-Namdo. In the region near the fighting front such duties fell to civil assistance officers and enlisted men with the divisions and corps. A chaotic period followed when the Chinese surged south, recreating the scenes of July against a backdrop of plummeting cold instead of breathless heat. As new waves of refugees, including many North Koreans, fled the Chinese, the United Nations Command sought to channel them into peninsulas and onto islands out of harm's way and the Army's. South Korean police struggled to keep the main roads clear. As the fighting began to stabilize again, efforts got under way to exploit the refugees for labor, to resettle them out of the danger zone, and to diffuse them among the settled population in hopes of reviving the nation's shattered economy.⁴²

The Japan Logistical Command, meanwhile, shipped medical supplies for relief in basic medical units modeled on the standardized medical maintenance units used by the Army—medicines and supplies to serve ten thousand people for one month. Small, forty-bed hospital assemblies were also sent, enabling war-ravaged civilian hospitals to reopen, or new ones to be established. Vaccines were procured almost entirely in Japan, another boost for the rapidly growing Japanese industry in high-quality biologics. Donated supplies from U.N. nations arrived in Yokohama to be sample-tested, stored, and shipped to Korea when requisitioned by the Eighth Army. On 11 January 1951 the Headquarters, Civil Assistance, Eighth Army, was renamed the United Nations Civil Assistance Command, Korea (UNCACK). Its duties, as before, were to requisition and distribute supplies and to plan, in conjunction with the South Korean government, for their proper use. UNCACK represented the maturing of the civil assistance structure in a form it was to retain, with only minor changes, until July 1953 (*Chart 3*).⁴³

The winter of 1950–51 was a bad time, only a little less so for settled Koreans than for refugees. The weather was harsh. Bandits and guerillas ravaged the hill districts, and police and army units waged an intermittent war of extermination against them. Stress and hunger lowered resistance to disease, and two large groups lacking immunization had joined the population—refugees from the North, now scattered over the southern provinces, and babies born since the outbreak of war. In December rural areas experienced outbreaks of smallpox, which continued through the winter and into the spring

⁴¹Extract of Ltr, Brig Gen Crawford F. Sams, Chief, Public Health and Welfare Section, SCAP, to Charles C. Furman, Chief, Recruitment Branch, Overseas Affairs Section, DA, 18 Dec 50, HSF (Sams-1950), HRB.

⁴²Military History Section, FEC, "Civil Affairs/Civil Assistance Problems," pp. 1–2, 5–7, 9–14, 38, RG 319, MMHB.

⁴³*Ibid.*, pp. 6–7, RG 319, MMHB; JLCOM, Annual Report of Medical Service Activities, 1950, file 319.1–2 (JLCOM) Far East-1950, HRB.

months, hitting hardest in regions where fighting made disease control impossible. Forces entering reconquered provinces near the 38th Parallel found that widespread typhus epidemics had occurred. The first six months of the new year saw thirty-eight thousand reported cases of typhus, forty-seven thousand of smallpox, and eighty-eight thousand of typhoid, the last a sure sign of polluted water supplies and inadequate sanitation. UNCACK faced not only the problems of a brief crisis but also the continuing ones of a poor and backward nation utterly without resources to meet the devastation of war.⁴⁴

In May 1951 UNCACK estimated that almost 4.5 million displaced persons were in South Korea. An unknown number lived north of the Han River; nearly 1.3 million lived south of the Han, in Kyonggi Province alone. Some 60,000 were relocated from the mainland to the large island of Cheju in the Korea Strait, while 78,000 on Koje provided an element of volatility to the mountainous isle that was shortly to receive the main body of enemy prisoners as well. Carrying their belongings in A-frames, leaning often on sticks, wearing (if they were fortunate) quilted coats over pajama-like suits with baggy pants tied at the ankles, the refugees formed an almost indistinguishable mass, their individual stories of fear and flight known to few but themselves. To feed and clothe them, to dust and inoculate them, to shelter the orphaned, and to provide at least tent hospitals for the sick remained the foremost concerns of civil assistance personnel.

Civil assistance efforts also helped another group, the civilian laborers, whose services had become essential to the U.N. army. They carried supplies on their backs over rough terrain, built roads, repaired damaged bridges and railroads, worked at supply points and ammunition dumps, and so forth. Heavy concentrations of such labor immediately behind the fighting lines and around the port of Pusan created new needs for food, clothing, blankets, shoes, and medical supplies—all contributed through the civil assistance program. UNCACK estimated that about one hundred thousand men were involved, divided about equally between the corps and division areas forward and the logistical command areas to the rear.

Medical support extended beyond these special groups to the entire civil population. A systematic program got under way to immunize all citizens against typhus, typhoid, and smallpox in response to the epidemics. People in coastal areas and port cities received shots against cholera as well. As UNCACK personnel increased in numbers, supervision and assistance for Koreans participating in the public health and information programs became more thorough. Training courses were held for provincial and city civil assistance teams and local sanitation workers. Villagers received instruction in the basics of public health, and cleanup campaigns began at the village level. Hospitals and dispensaries increased in number, providing free care to about half the population. Funding came from a variety of sources, the Congress of the United States being the largest contributor under a program known as Civil Relief in Korea (CRIK). CRIK funds went for food, clothing, shelter, fuel, medical supplies, and reconstruction materials. At the end of 1951 SCAP reported that a "sound, expertly

⁴⁴FEC, Annual Report of Medical Service Activities, 1951, pp. 173–76, HRB.

planned, well conducted, highly successful environmental sanitation program" existed in Korea. Further, Koreans were doing much of the hands-on work, which implied a permanent gain in national understanding of basic public health.⁴⁵

The following year saw more progress in stabilizing the rear areas. Rehabilitation of water systems continued on a routine basis, with inspections and surveys by UNCACK sanitary engineers to ensure proper construction and disinfection. The payoff for years of effort appeared as rates of illness responded to the programs of environmental control and immunization. Striking declines were registered in the diseases most closely associated with the disruption of war. Cases of typhoid, according to UNCACK, declined from about 69,000 to 2,400; of typhus, from 31,000 to 721; and of smallpox, from 40,000 to 885. Recalling some of the earliest triumphs of modern medicine, control of these diseases rested upon the classical methods of improved sanitation, vector control, and immunization. In 1951 the three diseases claimed over twenty-four thousand lives in South Korea; in 1952, fewer than six hundred.⁴⁶

Of great importance, though less publicized, was the program of improving the health of Korea's food and draft animals. CRIK funds supplied and made possible the rehabilitation of national and provincial veterinary laboratories. Vaccines from the same source made possible nationwide programs of immunization against hog cholera; Newcastle disease, which affects chickens; and rabies. In a nation that depended heavily on animal muscle, and among a people chronically short of protein, such improvements had direct implications for human health and the national economy.

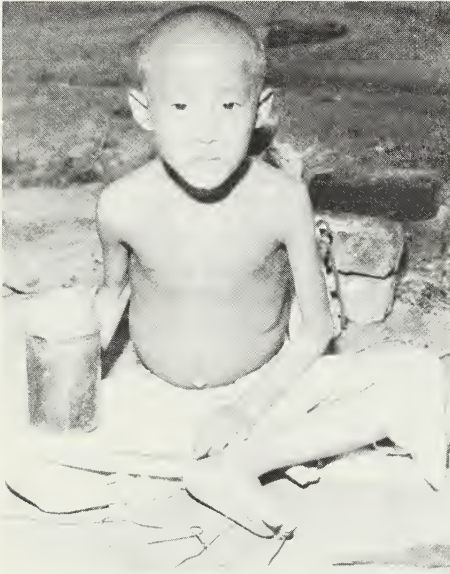
Success was not, of course, universal. Tuberculosis continued as the greatest and most baffling problem. In December 1952 the South Korean Ministry of Health reported that 1.3 million Koreans suffered from the disease—some 6.5 percent of the population, most of them younger people. An intensive program of tuberculin testing to locate victims began during 1952, aimed especially at children. UNCACK personnel supervised, while Korean doctors and nurses carried out the effort. But many doctors had been drafted into the ROK Army, and the government's health budget could not support its part of the program. New momentum was gained in 1953, when some four hundred thousand tests were administered, but reporting remained slow. Tuberculosis proved itself in Korea, as it had in Japan, a most resistant menace. Other difficulties showed during the spring of 1952 in a renewed rise in smallpox, mostly among nonvaccinated children, though in this case improved reporting procedures may have created the illusion of a rise over 1952.⁴⁷

Most basic to Korean health then and in the future were the country's own resources in hospital plants and especially in professional skill. The former

⁴⁵*Ibid.*, pp. 176, 181 (source of quotation), 225–29, HRB. See also Orlando Ward, *Civil Assistance in Korea* (FEC Printing Plant, 1951).

⁴⁶KCOMZ, Report of ETMD, September 1952, p. 21, file 350.05 (KCOMZ) 1952, HRB; J-5, Headquarters, Far East Command, United Nations Command (hereinafter cited as FEC/UNC), *United Nations Command Civil Assistance and Economic Affairs—Korea, 1 July 1952–30 June 1953*, p. 15, LIB.

⁴⁷FEC/UNC, *Civil Assistance and Economic Affairs*, pp. 15–17, LIB.



WAR ORPHAN SUFFERING
FROM MALNUTRITION

former proved far easier to increase than the latter. By late 1951 civil assistance had made possible the opening of all hospitals where damage was not beyond repair. At the end of June 1952 government agencies were running 97 hospitals and almost 500 dispensaries, with a total bed capacity in excess of 9,000. Missionary hospitals provided another 200 beds and private hospitals almost 1,300. A year later government bed capacity had increased to 9,700 and missionary to 550. The ROK Army was, of course, operating its own system.

A deficient supply of trained doctors remained the chief weakness in the system and in the efforts of civil assistance to provide an adequate health program for the nation. Korean doctors were divided into three categories: those who had graduated from

approved medical schools; those who had passed government examinations after a little formal training; and those whose training was limited to an apprenticeship. In early 1953 the number of physicians in all three categories to serve a population of about 20 million totaled 5,237. One doctor, often of dubious credentials, for every 3,800 persons was a statistic that would have horrified the American Medical Association, for the poorest American states counted no less than 1 to 2,200 during the height of the Second World War. But not all the Korean doctors were available for the general population; 1,350 were in the ROK Army, and others were out of the country or were government officials or teaching in government schools. Many Koreans no doubt continued to depend for most of their medical problems on the 5,000 herb doctors who, as in times past, practiced Chinese medicine, passing on its lore to their apprentices.⁴⁸

As a result, UNCACK estimated that fewer than 800 doctors were in private practice in the whole Republic of Korea, and "most of these [were] either in or near major cities."⁴⁹ Early in 1952 the command converted a truck into an experimental mobile clinic, which began operation in the refugee-crowded South Chungchong Province. Success was immediate. UNKRA agreed to furnish four more mobile clinics, supplying the necessary drugs and training Korean staffs. All five facilities were in operation under UNCACK by early 1953, when the United Nations Command supplied a sixth clinic to operate on the large island of Cheju, also crowded with refugees. With the clinics maintained

⁴⁸Ibid., pp. 17-18, LIB; Fishbein, *Doctors at War*, p. 83.

⁴⁹FEC/UNC, *Civil Assistance and Economic Affairs*, p. 18, LIB.

by the government, by missionaries, and by voluntary agencies, the mobile units brought at least the rudiments of care while they sought out medical data on the masses of Koreans who otherwise would not have seen any doctors at all.

The time, cost, and technical expertise required to train doctors was a formidable stumbling block, one that endured until long after the war's end. The military pitched in, however. The Korean Communications Zone (KCOMZ) adopted a policy of aiding Korean medical education. American and other U.N. medical officers served as part-time instructors at medical colleges in the communications zone, and the KCOMZ surgeon frequently lectured to the faculty of Taegu Medical College. U.S. Army instructional films were loaned to the colleges to assist teaching. The language barrier was particularly great in communicating technical subjects. Whether, as some officers believed, speaking slowly and distinctly aided comprehension is doubtful. Yet many Koreans were picking up a smattering of English, and lectures were mimeographed and distributed three to seven days before they were delivered to enable students (and faculty) time to puzzle them out.⁵⁰

In many ways the broadest contribution of the American forces came after the armistice. In July 1953 UNCACK was reorganized as the Korean Civil Assistance Command. With no more battlefield casualties to treat, military doctors and health facilities provided greater aid to the civilian population. The mission of maintaining and improving public health during wartime shifted into a program of rehabilitation and reconstruction, to which the Korean government as well now could devote a larger proportion of its meager resources. These developments lie outside the scope of this chapter; however, the trends that were to make South Korea a modern nation in health care during the generation that followed the war apparently rose from a foundation laid in the darkest days of the nation's recent history.

Korean Soldiers and Laborers

Though the demands of the ROK Army drained civilian doctors from a nation that had few enough to begin with, the program of health training in the army to which the United Nations Command contributed had clear long-range implications for the improved care of all Koreans. Health workers in army schools received instruction in arts they later would apply in civilian life. The ROK Army's health discipline transmitted the message of basic public health and sanitation to soldiers, many of whom had lived until the war in conditions approximating the Middle Ages in the West. At the same time, U.N. hospitals and dispensaries served the needs not only of Koreans drafted into the American divisions to augment their strength (KATUSAs) but also to members of the Korean Service Corps (KSCs) who supplied unskilled labor to the fighting forces. One of the evacuation hospitals, the 171st, served the Korean Service Corps alone, and evacuation was entirely through American channels.

⁵⁰KCOMZ, Annual Report of Medical Service Activities, 1952, encl. 1, p. 4, HRB.

Building up the ROK Army's medical capability to serve its own troops was a frustrating and arduous endeavor. According to the available evidence, the army received comparatively little help during 1950, except for medical supplies and random training of its medical and dental officers by their American counterparts. Many descriptions of ROK Army hospitals in this period were hair-raising because of—in the words of Colonel Dovell—"amputating geniuses" at work on the patients, fighting infection with the knife as American military surgeons had done during the Civil War. The ROK Army medical service remained autonomous, operating, even in corps areas, Class II installations for the evacuation of its own soldiers who were wounded while serving in Korean divisions under U.S. command.

The channel for providing American guidance and assistance to the ROK Army was the United States Military Advisory Group to the Republic of Korea (KMAG). Its headquarters in Taegu also included the senior medical adviser and staff that served in the Office of the Surgeon General, ROK Army. The incomparably greater resources in materiel and skill in American medical facilities made KMAG a frequent recipient of offers of assistance, for anything that served to increase the efficiency of the ROK Army was of evident value to the forces that served beside them. During 1952 considerable help was given in evacuation. Air evacuation was beyond the ROK Army's capability, and consolidation of ambulance and rail hauls reduced the burden on Korea's transport system. American surgeons were loaned to work on ROK Army patients when possible.⁵¹

In general, however, the ROK Army's medical organization and channels developed as mirror images of the U.N. system. Its tables of organization and equipment were less complex than for equivalent American units, and U.S. supply officers tried to keep them simple in order to reduce the strain on their stocks. Basically, the 60th Medical Depot received supplies and issued them to the ROK Army Medical Depot in Pusan, which then answered requisitions from its three forward platoons at Taegu, Seoul, and Chunchon. Shipments from Japan and the zone of interior, which went beyond the surpluses available in the Korean depots, met the needs of the ROK Army expansion during 1952. At KMAG three medical supply advisers on the staff of the senior medical adviser struggled to bring the ROK Army expansion during 1952. At KMAG three medical supply advisers on the staff of the senior medical adviser struggled to bring the wishes of Korean officers into line with their actual needs and with the available materiel. Establishing adequate control of supplies was difficult, and inefficiency and confusion were common.⁵²

Maj. Anthony J. Zolenas, Jr., a Medical Service Corps officer, served as a KMAG medical adviser to the South Koreans while the first American efforts were getting under way during 1950–51. He accounted the time "the best part of

⁵¹EUSAK, Report of ETMD, June 1951, p. 51, file 350.05 (EUSAK) 1951; EUSAK and KCOMZ, Annual Reports of Medical Service Activities, 1952, p. 13 of annex IV and pp. 1, 3–4 of encl. 1, respectively. All in HRB.

⁵²EUSAK, Annual Report of Medical Service Activities, 1952, annex V, p. 7, HRB. See also FEC and USAFFE, Annual Report of Medical Service Activities, 1952, p. 76, file 319.1–2 (FEC) Far East–1952, HRB.

his experience in Korea,” though it could not have been easy. His effort to reform their hospitals and medical supply system was assisted by two Koreans named Kim, an enlisted bodyguard and a Western-trained physician. Training manuals from Zolenas’ footlocker were translated, and a Korean practitioner of traditional Oriental medicine, with an energetic aide who was Western-educated, began using the materials to train medical technicians.⁵³

In early 1951 the Koreans got their first hospital assemblies from Japan, and Zolenas worked with them to develop supply and resupply procedures. Techniques had to be worked out gradually for dealing with people who were proud, intelligent, and wedded to a medical tradition whose complex lore formed part of their inherited culture. Colonel Dovell had selected an Edinburgh-trained board-certified obstetrician as surgeon general of the ROK Army, and through him elderly officers devoted to herb medicine were gradually shunted into jobs that were full of honor but deficient in the power to make mischief. For example, Zolenas’ assistant, Colonel Kim, learned about “a certain hospital commander [who] didn’t believe in operating or giving blood transfusions. . . .” In such a case there was only one thing to do: “send him to an induction center to examine recruits, or put him in charge of a dispensary [*sic*] where his old fashioned medical ideas wouldn’t do much harm.”⁵⁴

Liking the Koreans, Zolenas lived with them, ate their food, learned “never to appear to be imposing [your] ideas on them, but rather to let them mill [*sic*] over what you had to tell them and let them work the right answers out for themselves.” Correct as it was in essence, this diplomatic approach caused problems in meeting the brusque demands of war, for inadequate medical supervision was quite dangerous at any level, including the induction center. Another problem was that Korean resourcefulness, praised by Zolenas, also applied to theft. Maj. John B. Moore, the Eighth Army medical supply officer under General Ginn, later had many a tale to tell of the “horrible pilferage rate” in both American and South Korean medical stores. “No matter how much the ROK’s were issued, they were always complaining that they needed more.” The ROK Army medical warehouses falsified inventories to cover up thefts, as Americans discovered in the summer of 1953 when they staged surprise raids on their ally’s stores. But in a poor and long-exploited land, theft was almost honorable. It was the traditional medicine for poverty.⁵⁵

In September 1952 the ROK Army Medical Field Service School reopened at Masan under KMAG, commanded by an American Medical Service Corps officer. The school since its original founding in 1949 had a checkered history, marked by persistent poverty. The new school copied the methods of its counterpart at Fort Sam Houston, Texas, drawing instructors from the faculty of the institution and following its curriculum. Officer and enlisted student quotas were set by the ROK Army surgeon general, and Korean medical and medical service corps officers who had graduated from American service schools were in

⁵³Interv, Samuel Milner with Col (Ret.) Anthony J. Zolenas, MSC (hereinafter cited as Zolenas Interv), 13 Jul 66, p. 11, AMEDD Oral History Collection, HRB.

⁵⁴Ibid., p. 17, HRB.

⁵⁵First quotation from *ibid.*, p. 15. Second quotation from Moore Interv, 28 Jul 66, p. 2. Third quotation from *ibid.*, p. 7. All in HRB.

demand for their fluent command of English as well as their clinical and military knowledge. Instruction was in Korean, but knowledge of English technical terms was required of all students, who included doctors, administrators, nurses, and enlisted men. Courses combined lectures and demonstrations with field exercises. The area near Masan had seen some of the deadliest fighting of the Pusan Perimeter, and descriptions of the region mention not only the heavily wooded area with parade grounds, where the school was located, but also a training area in a nearby mountain pass, where field evacuation and first aid could be studied under conditions of simulated combat. Through their school men and women of improved skill and practical experience began to filter back into the ROK Army and, conducting unit programs on environmental sanitation and individual hygiene, to affect the outlook of masses of young Koreans.⁵⁶

Yet when all is said and done, ROK Army medicine by the end of the war was good only by comparison with that of other Asian armies and its own grim past. In the spring of 1953 American press reports raised questions about the efficiency of the South Korean medical service in treating its wounded men. The Office of the Surgeon General checked into the situation. Analysis showed that the ratio of killed in action to wounded in action was 1 to 3.14 in the ROK Army as against 1 to 5 for the U.S. Army, implying that less adequate evacuation resulted in more deaths among seriously wounded South Koreans. Of the wounded who reached medical channels, however, only 1.55 percent died, fewer than in the American Army. The reason may well have been the same: the arrival of a smaller number of seriously wounded to swell the death total. The fact that many serious cases were evacuated through American channels also may have contributed in part to the figures, reflecting the ROK Army's continuing problems in handling evacuation.

Overall, Surgeon General Armstrong judged that the ROK Army medical service was probably the best in Asia, comparing favorably with that of the U.S. Army in the early twentieth century. South Korean medics had improved since 1950 in striking fashion; in no equal period of time had their U.S. counterparts made a similar advance. By 1953 a South Korean neurosurgical team was handling casualties in professional fashion. "If, as alleged," wrote Armstrong tartly, "twice as many wounded South Korean soldiers are dying after reaching South Korean medical channels, as compared with our current record, the South Korean Medical Service is to be congratulated. I question whether they have attained this standard since it would compare with our own in World War II."⁵⁷

Exhibiting a mixture of defensiveness and optimism, like a parent with a slightly backward child, Armstrong refuted in a similar vein press complaints about the way the ROK Army was fed.⁵⁸ Again relying (as in the case of the

⁵⁶See Arthur D. Sullivan, "The Training of Korean Army Medical Service Personnel," and Hun Chan Yoon, "Preventive Medicine in a Korean Division," both in *Medical Bulletin of the U. S. Army Far East* 11 (October 1953): 187-89 and 190-91, respectively. See also Philip J. Buckler, "An Introduction to the Medical Field Service School, Republic of Korea Army," [1952].

⁵⁷Memos, Maj Gen George E. Armstrong, Surgeon General, DA, to Secretary of the Army, 24 and 27 Feb 53, subs: Medical Service of the ROK Army, file 333.5 (Far East Command) AA, 1953, Box 69, Accession no. 56A-179, RG 112, WNRC.

⁵⁸The following section is based on Summary of Significant Findings and Recommendations of the Report to the Chief Surgeon, United States Army Forces, Far East, 20 Jul 53, sub: Report of

POWs) on analyses of the caloric value of the official ration, the surgeon general concluded that the feeding of the South Korean Army was adequate, with 3,800 calories a day for front-line troops and 3,100 for those in the rear. Malnutrition, he pointed out, accounted for less than 1 percent of admissions to ROK Army hospitals.

The fact that all the calories for men at the rear came from rice might in itself have raised some questions about this easy reply. Here the matter rested, however, until the Sandstead-Koehn team reported in early summer. Their account made dismal reading. “[It is] estimated that approximately fifty percent of the men inducted into [the] ROKA failed to reach front lines because of malnutrition. Effectiveness of those reaching front lines is impaired because of malnutrition. New ROKA inductees were found to be in marginal nutritional state. In each successive stage of training, progressive deterioration in this nutritional state was noted.” Excessive work—a sixteen-hour training day supplemented by hard labor on roads and construction projects—without a compensating diet was the apparent cause. The herb doctors who watched over their health apparently saw nothing wrong. The end result was an army that suffered from almost every form of physical debility associated with inadequate food: weight loss and protein and vitamin deficiencies, especially in A, B, B2, and C. Men in forward areas, guarding the line, exhibited nutritional edema as well as emaciation and weakness. The deficiencies were “of serious nature undoubtedly inimicable [*sic*] to the effectiveness and stamina of the ROKA.”

The team recommended immediate reduction of the training schedule to eight hours a day, excusing combat trainees from labor battalion work, evacuation of men with “definite debilitating malnutrition” from the line to rest camps, and a ration supplement of brewer’s yeast for all. Long-range improvement would require modifying the basic ROK Army rotation, abandoning the practice of paying troops a stipend to enable them to buy part of their own food, and issuing rations under rigid control at large breakdown points. (The report did not make clear whether the purpose of this reform was to maintain quality or reduce graft.) Similarly, the rations of the KSCs should be raised in caloric value and improved with vitamin supplements, especially A and C. The team urged action on the diplomatic level to appoint an American nutritional consultant to the United States Army Forces, Far East, specifically to advise the South Korean government on how to feed its troops.

In all, this startling analysis, coming just at the end of the fighting (it was circulated to top U.S. officials during July 1953) raised serious questions about the causes and consequences of malnutrition in Syngman Rhee’s army. Did the conditions under which young men were better fed in a war-shattered civilian economy than in their nation’s army result from sheer nutritional ignorance, official venality, or the practice of allowing South Korean soldiers in part to feed themselves, again ignorantly, with a small allowance of money? The ROK Army often had performed in disappointing fashion during the war. To what extent could this be attributed to starvation? Though the fact was not mentioned in the

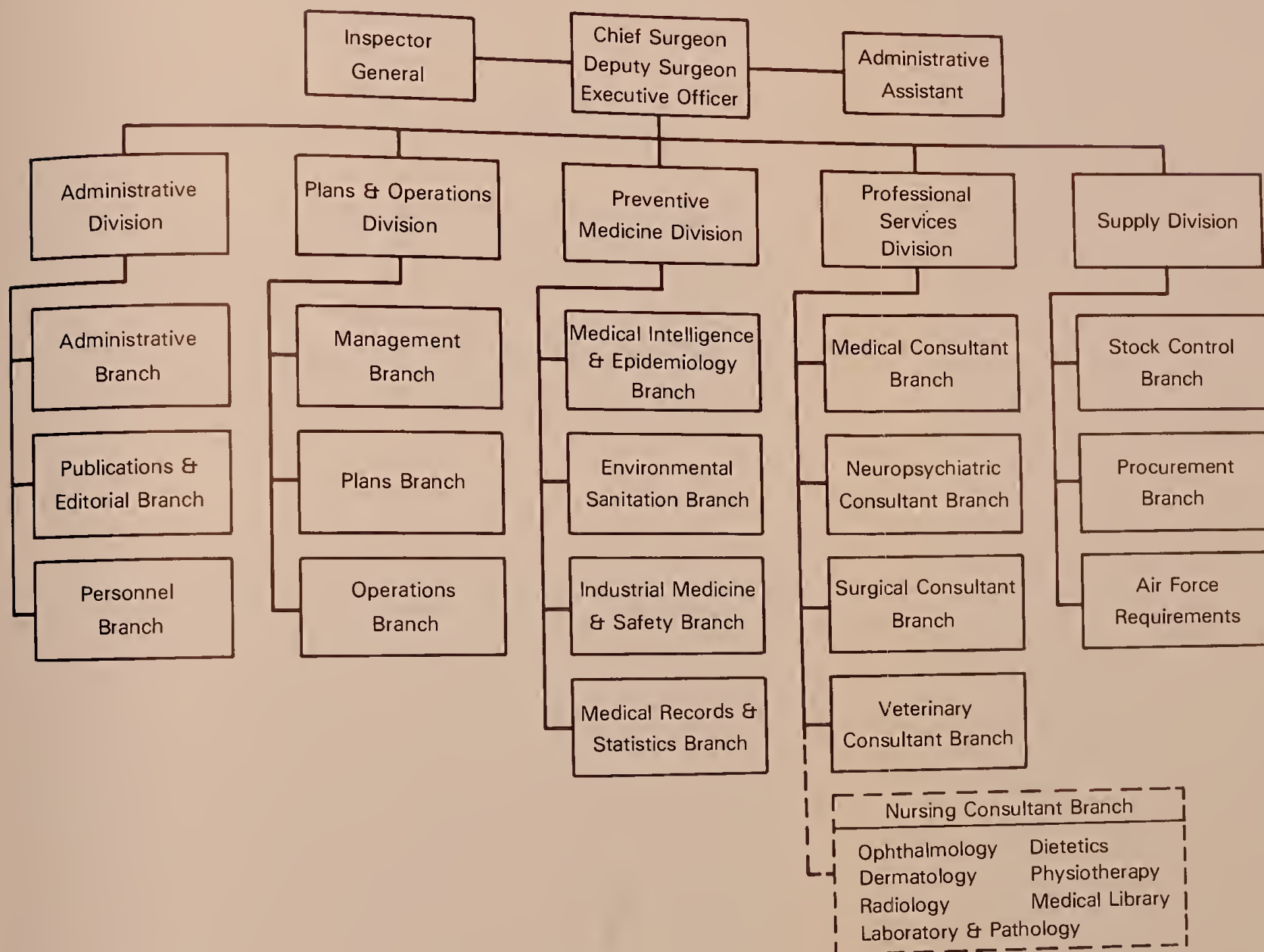
Nutrition Survey of ROKA, KSC, and PsW, attached to DF, Prentiss to Long, 24 Aug 53, and to related correspondence on same subject, RG 112, WNRC. All quotations therein from this source.

summary report, Vitamin A deficiency can cause night blindness, a most undesirable condition in a war where enemy attacks usually were launched after dark.

The question of the American Medical Service's own responsibility also arose. Clearly it had no official duty to oversee the feeding of the ROK Army. Yet its contacts with that army were intimate, and the existence of widespread nutritional edema and cachexia among front-line troops probably would have been a matter of some interest to the United Nations Command. Because the Medical Service was quick to take a due measure of credit for advances in ROK Army medicine, it might well be charged with regrettable lack of alertness in spotting a serious and fundamental failing in an army over which an American headquarters exercised command, and upon which all U.N. forces in Korea depended for the defense of wide sectors of the line.

As a theater of tragedy, melodrama, and occasional gross comedy, the Korean rear areas yielded nothing to the battle line. Indeed, there were times when the sharpest battles were at the rear. For all its failings, the United Nations Command followed medical policies that were humane in principle if sometimes deficient in practice. The lot of POWs and the much-battered Korean people was bettered, major diseases suppressed, and at least minimal care brought to many whose normal state in time of peace was to live and die without any medical attention at all. Of the four classes of South Koreans considered here—refugees, soldiers, KATUSAs, and KSCs—those under the most direct control of the American medics did best. Ironically, this meant that the ROK Army troops on the line, depending as they did primarily on their government and their own nascent medical service, in many ways did worst of all. Throughout South Korea, the most typical medical endeavor continued to be a holding action against great odds. So it would remain, despite some promising efforts, until peace made possible a new beginning for all the victims of the war.

CHART 4—ORGANIZATION OF THE MEDICAL SECTION, UNITED STATES ARMY FORCES, FAR EAST, DECEMBER 1953



Source: United States Army Forces, Far East, Annual Report of Medical Service Activities, 1953, p. 4, file 319.1-2 (USAFFE) Far East-1953, HRB.

CHAPTER 11

The End of the Fighting

Nineteen fifty-three began with the war, the fighting front, and the relations of the contending powers all in a state of deep freeze. Routine patrol activity and a few unsuccessful attacks on strongpoints by the Communist forces occupied the men on the line. From the United States Army Forces, Far East (USAFFE), headquarters to the forward bunkers habit ruled a conflict that had settled into routine. On the world scene harbingers of change appeared with the inauguration of Dwight D. Eisenhower as president of the United States in January and with the death of Russia's dictator, Joseph Stalin, in March. But the early months of the year gave small indication of the events to come.

The Medical Picture

The Medical Section, USAFFE, had reached full development (*Chart 4*). Its major functions had matured but changed little from 1952. In evacuation, air still predominated, both for carrying casualties from Korea to Japan and from Japan to the zone of interior, though naval hospital ships occasionally played a part when rotating back from assignments in the war zone. The 801st (later redesignated the 6481st) Medical Air Evacuation Squadron was chiefly responsible for moving patients within Japan and from Korea to Japan. The 1453d Medical Air Evacuation Squadron of the Military Air Transport Service carried evacuees from Japan and the Ryukyus Command to the United States. Army medical regulating officers operated at Seoul for the Eighth Army, at Pusan for the Korean Communications Zone (KCOMZ), and at Camp Zama for the Far East Command. Typically, a hospital would report on patients ready for evacuation to the appropriate medical regulating officer, who would then contact the 6481st at Tachikawa Air Base to provide transport. The officer at Camp Zama, upon notification from Korea, designated the hospitals in Japan that were to receive the evacuees. All services were involved, for liaison officers from the Air Force and Navy coordinated use of their own services' hospitals. U.N. personnel were hospitalized in the Tokyo area. Though as a rule each service cared for its own people, hospitalization was primarily on an area not a service basis, and in

consequence individual American wounded or sick might find themselves in any convenient facility.¹

Throughout, the customary evacuation policies ruled—30 days for Korea and 120 for Japan. On return to the United States evacuees received their hospital assignments from the Armed Services Medical Regulating Office in Washington, D.C., with most Army patients going to the large general hospitals for specialized care. What had once been a flood, however, had fallen by the early months of 1953 to a relative trickle. For all three armed services, a total of about two thousand battle casualties and fourteen hundred others were received from Korea during the first six months of 1953. The Army had slightly more casualties than the Marine Corps, while the Air Force, with only eight wounded, exhibited almost a peacetime pattern.²

Within Korea the fact that the KCOMZ still had no clearly defined mission to provide medical support for the Eighth Army caused some difficulties. Bed requirements and staffing in the communications zone had to be justified on the basis of its troop strength alone. Only the lack of activity on the front prevented the deficiency from having serious consequences. The problems of evacuating U.N. patients through American channels were likewise of little practical importance. Over the years the situation had grown familiar, and linguistic difficulties continued to be minimal, even with tongues like Amharic (Ethiopian), which almost no Americans spoke. Units still provided their own medical personnel at the lower echelons, and the Ethiopian surgeon, by good fortune, was an English-speaking European versed in a number of languages. The commander of the Ethiopian unit found that the system of evacuating through American channels “works very satisfactorily. We don’t think any changes in the present arrangements are necessary.”³

Supply similarly had become standardized and remained virtually unchanged through 1953. Lack of fighting in the early part of the year enabled the inventories at medical depots to reach their most satisfactory condition since the beginning of the conflict, with materiel on hand that proved very useful when the final enemy assaults began in the summer. The source of supply was, as before, the Japan Medical Depot, shipping to the 60th Medical Depot in the KCOMZ. In turn the communications zone depot supplied the Eighth Army through the 6th Army Medical Depot, the Republic of Korea (ROK) Army through its medical depot, and the units of the zone directly. The Eighth Army and the ROK Army together took about three-fourths of the materiel issued, while the KCOMZ absorbed the rest. As before, the 60th Medical Depot operated under KCOMZ’S subordinate command, the Korea Base Section. One oddity of the early part of the year was the reluctance of depot personnel in Japan to maintain stocks at a high level. Rotation and the draft had by now eliminated all workers with experience of heavy combat, and as a result medical supply people

¹USAFFE, Annual Report of Medical Service Activities, 1953, pp. 80–93, file 319.1–2 (USAFFE) Far East–1953, HRB.

²Armed Services Medical Regulating Office, Summary of Major Events and Problems, 1 Jan 53–30 Jun 53, pp. 2–3, file 314.7–2 (Army Medical Service Activities, 1 Jan–30 Jun 53), Box 2, RG 112, MMFB.

³Quoted words from Military History Section, FEC, “History of the Korean War,” vol. 3, pt. 2, sec. B, “Inter-Allied Co-operation During Combat Operations,” Ms no. 8-5.1A AI V1, RG 319,

found it hard to believe that the levels established by their predecessors had any relevance to things as they now were. Fortunately, General Ginn knew better, and supplies to meet the last attack were either on hand or on the way when the need arose.⁴

The personnel picture in USAFFE continued to resemble the familiar image of a revolving door. The problem was not only the old one of rotation—which as late as September was still calculated on the basis of constructive months of service—but of special early-out provisions that began to emanate from the Department of the Army following the first breakthroughs toward peace in the early spring. “What the public may regard as overstaffing,” wrote the surgeon general to General Shambora, “in fact, is not such. However, we already have begun to receive a trickle of letters originated by individuals in oversea[s] commands and coming to us through various channels including members of congress. I anticipate that this trickle will grow into a fair size stream and refutation of the allegations [of overstaffing] is most difficult without breaking security.” Unpredictable changes in policy made advance planning and requisitioning of replacements as baffling a problem as the physical turnover itself. Not until October did a fixed-tour requirement for service in the Far East Command finally promise a return to order. Meanwhile, under pressure from civilian medicine, the Army rushed to release its physicians upon the mere promise of peace.⁵

Doctors in the Far East Command continued to be young, professionally able, and short on field experience. Reflecting the obsessive specialization of American medicine as well as the Army’s own deliberate policy, too many medical officers were trained in specialties and too few in general practice. Because of the shortage of general practitioners, who were needed most, the specialists had to fill slots for which they overqualified. Men of sophisticated training had to go forward into field assignments that provided them much physical discomfort and little professional excitement. Meanwhile, the lack of experienced officers to fill command positions brought older specialists into jobs as division surgeons and hospital commanders, rather than allowing them to use their clinical skills. The problem of finding officers who combined military experience, administrative knowledge, and board certification was not easily solved, and, on the whole, experience continued to be at a greater premium than clinical expertise. Shortages became more pronounced in units that were closer to the sound of gunfire. The Eighth Army complained of a “continuing shortage” throughout the year, extending to all grades, but critical in field-grade officers. Of 130 field-grade Medical Corps officers authorized, only 43 actually were assigned at the end of 1953; only 6 had previous command experience and

MMHB. See also KCOMZ, Annual Report of Medical Service Activities, 1953, p. 3, file 319.1–2 (KCOMZ) Far East–1953, HRB.

⁴USAFFE and KCOMZ, Annual Reports of Medical Service Activities, 1953, pp. 94–96 and pp. 3–4, respectively, HRB.

⁵Quoted words from Ltr, Maj Gen George E. Armstrong, Surgeon General, DA, to Maj Gen William E. Shambora, Chief Surgeon, Medical Section, FEC, 16 May 52, p. 2, 319.1 (Far East Command) AA, 1951–52, Box 69, Accession no. 56A–179, RG 112, WNRC. See also references to Public Law no. 83–84, 29 Jun 53, and Department of the Army Msg no. 415370, 30 Apr 53, and Msg no. 438420, 24 Jul 53, cited in USAFFE, Annual Report of Medical Service Activities, 1953, pp. 6–7, HRB.



CARE OF THE FEET

only 3 of the 6 division surgeons had staff experience.

Veteran Medical Service Corps officers were likewise in short supply, diminishing a source of compensating strength. Because they were so often pulled into Medical Corps administrative slots, their usual role in training medical units for combat was less easy to perform. Nurses were at about 70 percent of authorized strength. In the Army as a whole, the sharpest drop in any category during 1953 was in Medical Service enlisted men. Falling draft quotas at home in the first six months of the year were reflected in a decline from about eighty thousand to sixty-four thousand—a 20 percent drop-off. But the Far East Command apparently was not affected before the armistice.⁶

Preventive medicine, best performed under conditions of stability and careful routine, reached a high level of competence and success despite the problems of the command. At division and corps headquarters general medical officers who had taken a short preventive medicine course at the Medical Field Service School in Texas but who had no lengthy experience in the field usually filled available slots. Or nonmedical officers with a background in civilian public health might take on the job. The competence displayed by the latter group indicated that very elaborate training was not a practical necessity for the work in Korea. (At major headquarters, however, fully qualified medical officers, sanitary engineers, and entomologists were the rule.) One preventive medicine control detachment served with each division, carrying out the work of sanitary inspection, insect and rodent control, and so forth. Technical supervision from the Office of the Surgeon, Eighth Army, supplemented the knowledge of the division surgeons but led to some grumbling about interference from above. By year's end, however, the units were still attached to the divisions but under Army control.⁷

Health discipline for the troops had reached its highest level of development. Every man had to shower once in five days; at the battalion shower point he also received a complete change of clothing. During cold weather he spent several hours in a warming bunker every three to four days. In effect, this bunker was a

⁶Sources for the above paragraphs include: EUSAK, Annual Report of Medical Service Activities, 1953, especially pp. 2–3, file 319.1–2 (EUSAK) Far East–1953; Personnel Division, OSG, Summary of Major Events and Problems, in Source Material for Summary of Medical Service Activities, 1 Jan 53–30 Jun 53, p. 13, file 314.7–2 (Army Medical Service Activities, 1 Jan 53–30 Jun 53). Both in HRB.

⁷USAFFE, Annual Report of Medical Service Activities, 1953, p. 69, HRB.

dayroom where he read, wrote letters, washed his clothes, and received a haircut. Rest periods in a rear area were allotted on a rotating basis, and, as in the past, each man received a five-day rest and recuperation leave in Japan at some time during his service in Korea. Whether or not combat was occurring, the company aidman remained the key to maintaining health in his unit, especially while it was on the line. Each man had to change his socks daily as a precaution against trenchfoot, and one duty of the aidman was to inspect the feet of all members of his unit every day. The aidman also sprayed bunkers with disinfectant once a month and spread rat poison to control the rodent population. He checked the chlorination of water, distributed chloroquine weekly by roster, gave first aid, and kept an eye on latrine and mess facilities. He was, as usual, indispensable.⁸

No important new health problems developed during 1953. In the spring hemorrhagic fever repeated its by now familiar seasonal pattern. Despite intensive study by epidemiologists and ceaseless work in medical laboratories, the agent was not isolated, the vector was not found, and the natural reservoir was not identified. No therapeutic agent appeared. On the reasonable assumption that a virus caused the disease, that its reservoir was among wild rodents and its vector a chigger or mite, an extensive mite control program continued, with quartermaster laundries routinely soaking newly washed outer clothing in miticide. During the April to September season medics could congratulate themselves that only 148 cases were reported, as against 487 for the same period in 1952. Unfortunately, during the fall season 279 cases occurred, a few more than in the 1952 autumnal outbreak. Was the mite control program wrong in principle (as later proved), or was it improperly carried out? A carefully supervised program for an entire division was planned for 1954; however, the war ended with the mystery of hemorrhagic fever still unsolved and, more to the point, with even the pragmatic methods of field control in doubt.

Among other diseases, a few cases of smallpox surprisingly occurred among Army personnel, about one a month from December 1952 to March 1953. All were in the Pusan area, and all reflected unsuccessful vaccinations. Hepatitis declined throughout the Far East Command, with the greatest change noted in the Eighth Army area. With only 2.5 cases per 1,000 troops per annum, the forward areas were benefiting from the improved water, better mess discipline, and enforced lack of contact with infected civilians. More rigorous medical testing of civilian employees in rear areas, where they were widely employed, revealed that 4 percent of those who had passed earlier testing had active tuberculosis. The use of routine X-rays thus provided a new means of guarding troops against one of the commonest of local ills. Malaria control was even more effective in 1953 than in earlier years. In Korea the reported incidence of 8.4 per 1,000 troops per annum in 1951 had declined to 3.2 in 1952 and dropped again to 1.9 in the last year of the war. Primaquine treatment of Korean veterans returning to the United States appeared to be successful, with a resulting drop in the cases among rotated Army personnel. More than 10,000 such cases were

⁸Samuel Hurewitz, "S.O.P. for Aid Men of Infantry Companies," *Medical Technical Bulletin* 4 (May-June 1953): 85-86; Hermes, *Truce Tent and Fighting Front*, p. 374.

reported in 1952, but only 848 came to light in 1953. Checking for toxic side effects of primaquine continued to be a tiresome chore for GIs and medics alike, for men taking the drug were supposed to report to the dispensary for fourteen days afterward. Nevertheless, primaquine appeared to destroy malaria parasites, rather than merely suppressing the clinical symptoms like earlier antimalarials, both natural and synthetic.

In Korea cold injuries declined with improved discipline and the low level of fighting. Aerial spraying of insecticides continued during warm weather, carried out jointly by the Fifth Air Force and Eighth Army. Vector control details were set up in every company and battery, or separate unit, and their members trained by the preventive medicine units. A newly established Preventive Medicine Association of Korea, which held regular monthly meetings, proved a valuable educational tool, especially because so many of the people engaged in the effort were to some extent amateurs. Every meeting was built around a lecture by a visiting consultant, or other expert, and all personnel involved in the work were encouraged to attend.

Prevention of disease extended to Koreans, both civilian and military. In the late summer and early autumn an epidemic of Japanese encephalitis swept the country, though few cases were reported among American troops. However, the needs of the local population and the ROK Army got increasing attention during the lull in the winter and spring and again after the signing of the armistice. The Preventive Medicine Association served as adviser to the Korean School of Public Health, giving assistance in planning curricula and providing lecturers from its own members and its visiting experts. A preventive medicine section was set up within the United States Military Advisory Group to assist the ROK Army. Members of the Korean Service Corps were surveyed in some divisions for tuberculosis, though the results at year's end were termed inconclusive. The prevalence of rabies in Korea's animal population—rabid animals had bitten about a hundred U.S. soldiers during 1953—led to an intensive program to immunize pets acquired by military personnel. Efforts to improve animal health apparently were due largely to civil assistance officers. Work with and for the Koreans would increase greatly after the armistice, but the final months of the fighting demonstrated concern and helped to lay a basis for future efforts.⁹

On the Line

In the forward areas the major innovation in organizing Eighth Army medical care was the activation of the 30th Medical Group on 25 March 1953. By early June this subordinate command had taken charge of the surgical hospitals, the separate medical battalions, the 1st Medical Field Laboratory, and an array of small units of company, dispensary, and detachment size. Its fundamental mission was to coordinate the operations of units providing third-echelon sup-

⁹USAFFE, KCOMZ, and EUSAK, Annual Reports of Medical Service Activities, 1953, pp. 62–79, pp. 5–6, and pp. 3–6, respectively, HRB.

port to the Eighth Army, and this comprehended evacuation; initial hospitalization; and area medical service, including dental care.¹⁰

As the largest medical field command ever assembled by the Army, up to the Korean War, the 30th Medical Group unified under a single headquarters evacuation and area medical service, previously the domain of the 163d Medical Battalion. Fixed-wing aircraft and the two Eighth Army evacuation hospitals remained outside its jurisdiction. Like the 52d Medical Battalion, which was attached to the medical group, the 30th's function was not to fix policy—that remained the concern of the Eighth Army surgeon, General Ginn—but to act as his executive agency, a sort of Eighth Army medical command. The group represented the third stage in defining the relationship between the Eighth Army surgeon and the field units. Colonel Dovell, patching together his jerry-built service in the early days of the war, had simply run everything himself, as far as possible. Colonel Page, a somewhat shadowy figure between Dovell and Ginn, apparently made few changes. But the increasing number of diverse units compelled action, and Ginn gave the 52d the functions of a group while he embarked on the bureaucratic ordeal of getting the larger headquarters he needed onto his troop list. Whether, with the creation of the KCOMZ and the winding down of the war, the group was as necessary in mid-1953 as it had been a year earlier is another question. Fully functional for only seven weeks before the armistice, the group saw plenty of action, for its brief wartime span coincided with almost continuous enemy assaults.

Under the group another new unit appeared in June with the creation of the 1st Helicopter Ambulance Company (Provisional) to provide a command structure for the isolated medevac detachments. This innovation completed a process begun in December 1952, when the 49th, 50th, and 52d Medical Detachments (Helicopter Ambulance) replaced the three functioning helicopter evacuation units. With this change the helicopter evacuation detachments formally became medical outfits, a part of the medical troop list, under tables of organization and equipment (T/O&Es). In February 1953 the three detachments were combined with a fourth unit, the 37th Medical Detachment (Helicopter Ambulance) and two paper units, the 54th and 56th, to form the new provisional company. Beyond all question, dedicated medical aircraft were now a reality, though proposals to bring small fixed-wing planes into the company did not materialize. Because training of Medical Service Corps officers as helicopter pilots had begun the previous autumn in the United States, the future of the medevac chopper as a true ambulance staffed and controlled by trained paramedics was clearly indicated, though no Medical Service Corps officer flew a helicopter in Korea before the end of the war.¹¹

By now both the power and the current limitations of the helicopter had become fairly clear. Though the figures are at best uncertain, it appears that medevac helicopters carried 5,040 casualties during the first twelve months of

¹⁰EUSAK, Annual Report of Medical Service Activities, 1953, p. 1, HRB. See also *ibid.*, annex I, 30th Medical Group, Annual Report of Medical Service Activities, 1953, p. 2, HRB.

¹¹8086th Army Unit, Military History Detachment, "Helicopters in Korea," pp. 5–6, Ms no. 8–5.1A AJ, RG 319, MMHB.

operation (January–December 1951); 7,923 during the second year (January–December 1952); and 4,735 during the last seven months of the war. Assuming that the twelve assigned machines were available throughout, a statistical convenience in view of the shortage of helicopters and the maintenance problems that put them into the shops six hours for every one in the air, each craft carried an average of about 1.5 casualties per day. During 1951, a year for which total hours of flying time are available, the medevac helicopter was in the air about one hour and fifteen minutes on an average day. Recognizing that nonmedical machines carried many patients unrecorded, the available figures suggest that medical helicopters carried between 3.5 and 4 percent of the 443,163 hospital admissions recorded for all causes.¹²

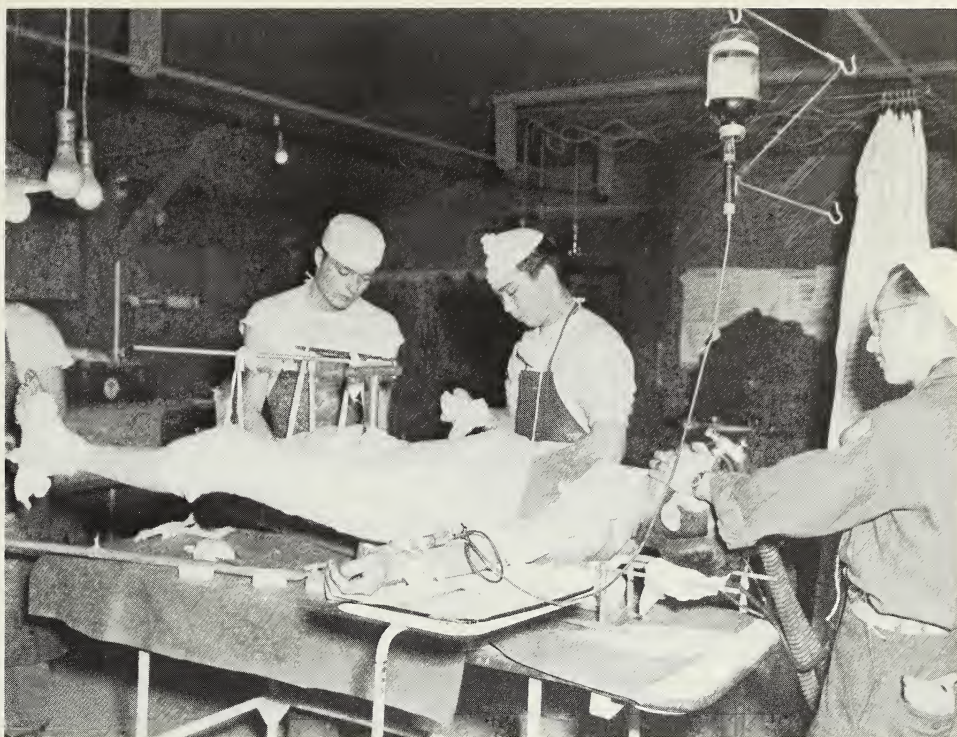
Of the helicopter's effectiveness in saving the lives of the seriously wounded, no more needs to be said here. A specialized vehicle of high cost and limited effectiveness, the medevac chopper won its fame as an evacuation vehicle under conditions that were unique to the Korean War. As a wealthy nation that admired technical innovation and placed a high value on individual life, the United States was well fitted to finance such a pioneering effort. Preexisting medical skills of a high order were necessary to make the trial a success, for only a medical service of great sophistication could have dealt competently with the massive and near fatal injuries that were the helicopter's specialty. The endeavor was not militarily significant, but it boosted morale by demonstrating that, against all purely material considerations, the nation intended to save every possible life. The typically high-cost, low-yield experimental period during the Korean War proved the potential of a vehicle whose future impact on all emergency medicine, both military and civilian, would be great indeed.¹³

Meanwhile, the helicopter's partner, the MASH, assumed its final form of the war, becoming at last the sixty-bed T/O&E surgical hospital of the manuals. The long-delayed troop list for fiscal 1953, received in January, authorized the changeover from the table of distribution strength to T/O&E size and makeup for the surgical hospitals. In the following months the MASHs underwent two changes in nomenclature as well. On 2 February, for example, the 8225th MASH was formally discontinued and the 47th Mobile Army Surgical Hospital activated, only to be redesignated on 25 March as the 47th Surgical Hospital (Mobile Army). Despite these vicissitudes, everyone continued to call the surgical hospital a MASH.

Yet the changeover did not go unchallenged. The USAFFE surgical consultant, for one, bitterly opposed General Ginn's plan on the grounds that the clearing stations were unequipped to perform surgery. But in the end the Eighth

¹²Ibid., pp. 36–37, RG 319, MMHB. See also Lt Col Spurgeon H. Neel, Jr., "Medical Considerations in Helicopter Evacuation," Address before the Medical Field Service School, Fort Sam Houston, Texas, 25 Jun 53, in *ibid.*, p. 153, RG 319, MMFB, and Table 3, "Numbers of Casualties and Hours Involved in Transportation by Army Evacuation Helicopters, Korean War, 1952–July 1953," in Dorland, "Army Air Ambulance Evacuation," ch. 2, p. 17.1, in fldr 20, box 2 of *Dust Off* Background Materials, RG 319, WNRC, which gives a grand total of 15,595 patients.

¹³See William G. Baxt and Peggy Moody, "The Impact of a Rotorcraft Aeromedical Emergency Care Service on Trauma Mortality," and the Editorial, "Helicopters in Emergency Trauma Care," both in *Journal of the American Medical Association* 249 (June 1983): 3047–51 and 3074, respectively.



MEDICS AT THE 47TH SURGICAL HOSPITAL FITTING A CAST

Army surgeon had his way. Already in the fall of 1952 the MASHs supporting Operation SHOWDOWN had begun to receive only nontransportable cases. In February 1953 Ginn issued a standard operating procedure defining the types of surgery to be performed in the clearing stations—in essence, minor operations that did not involve fractures of the long bones, penetrating wounds of the peritoneal or pleural cavities, major nerves, or the brain. He defined surgical principles and techniques for clearing stations and surgical and evacuation hospitals in order to standardize, as far as possible, what each level would contribute to the care of the patient.

For several reasons, however, the surgical hospital still was not located adjacent to the clearing station but rather 1,000 to 20,000 yards in the rear, depending on local terrain and the road net. The helicopter and improved ground transport combined to make this possible, but rotation made it desirable. MASH personnel received credit for only two constructive months instead of three, as they would have in division areas, an essential move to slow the turnover among their often decimated staffs.¹⁴

¹⁴8086th Army Unit, Military History Detachment, "Surgical Hospital in Korea," pp. 7–8 and 19, Ms no. 8–5.1A DN, RG 319, MMHB; 8225th MASH, Annual Report of Medical Service Activities, 1953, p. 1, file 319.1–2 (MASH, 8225th Army Unit) Far East–1953, HRB; L. Holmes Ginn, Jr., and H. Haskell Ziperman, "Surgery in Division Clearing Stations," *Military Surgeon* 113 (December 1953): 443–47. On rotation points, see comments of Col Dean Schamber, Inspector

(Continued)

In divisional medical battalions the old pattern continued of rotating off the line to rest areas, back on the line to replace another unit. Customary complaints followed any move. The new location, if previously occupied by another unit, usually was described as a mess. As cleanup and beautification proceeded, a rise in morale was recorded. Medical work was partly traditional, partly a creation of Ginn's new policies. In the clearing station, seasonal diseases came and went like the flowers of spring: upper respiratory infections during cold weather and hemorrhagic fever in its familiar two-humped pattern. Typical for 1953 was the experience of the 3d Medical Battalion, 3d Infantry Division. Beginning the year in reserve, the division relieved the 25th Infantry Division late in January and the medical battalion moved forward a few days later. In line with Ginn's policy it operated a consolidated clearing station with a 55-bed medical ward and 25-bed surgical ward, plus an admissions and dispositions section. It evacuated to the 44th Surgical Hospital (Mobile Army). Seasonal maladies brought a sharp rise in admissions during April, including 8 cases of suspected hemorrhagic fever. In June patrolling and probing gave way to fierce fighting as the enemy attacked the division sector. A total of 918 battle casualties flooded in, and the clearing station recorded 198 surgical procedures.¹⁵

The 115th Medical Battalion, 40th Infantry Division, encountered heavy action during enemy attacks in May and June, not only supporting its own division but aiding the overtaxed medics of the ROK 12th Division. During the crisis the 45th Surgical Hospital (Mobile Army) sent a surgical team, which set up in a hospital tent about a mile south of the clearing station. Facing augmented responsibilities, an increased number of units to support, and an enemy assault, the battalion operated at about 75 percent of its assigned strength; only two of its three clearing platoons could be manned, and the ambulance company did not have enough drivers to use all the vehicles. The unit traded support with other battalions. The 115th took care of the 3d Division artillery that was firing in support of the 40th Division, while, for a time during June, some casualties were evacuated to the clearing station of the 45th Infantry Division to save an hour's ride. Despite the pressure, the medical battalions seem to have liked the additional responsibility they had acquired under Ginn's system. A medical battalion," noted the commander of the 115th, "is capable of rendering medical service far beyond its designed capacity . . . without overtaxing its facilities or disrupting its operation."¹⁶

Ironically, the quickening combat signaled the approaching end of the war. Trying to gain as much ground as possible before peace came, the enemy hit Turkish and American outposts at the end of May and June. The unrelenting pressure forced minor withdrawals of U.N. forces. In June the main enemy

(Continued)

General, Medical Section, USAFFE, attached to 8086th Army Unit, "Surgical Hospital in Korea," RG 319, MMHB.

¹⁵3d Medical Battalion Command Reports, January–September 1953, files 303–MED (Command Reports, 3d Medical Bn, 3d Inf Div, Jan–Apr and May–Sep 53), Box 3082 (3d Inf Div, 303–MED to 303–SIG, Jan–Sep 53), Entry 429, RG 407, MMFB.

¹⁶115th Medical Battalion Command Reports, May–September 1953, file 340–MED (Command Reports, 115th Medical Bn, 40th Inf Div, May–Sep 53), Box 4222 (40th Inf Div, 340–MED to 340–REP, May–Sep 53), Entry 429, RG 407, MMFB.

drive shifted to the ROK Army lines in the east, with the 3d Division receiving its share of the fighting. Then on 18 June President Rhee of South Korea, in an attempt to disrupt armistice negotiations that threatened to leave his nation permanently divided, ordered his forces guarding nonrepatriate prisoners of war (POWs) to allow a mass escape. Now the Chinese prepared a massive assault seemingly aimed at convincing the South Koreans that they could not hope to fight on alone. Meanwhile, other attacks on U.S. held salients enabled the Chinese to improve their position at severe cost. The last attacks in mid-July pierced the ROK Army lines and compelled the United Nations Command to move forces from Japan to bolster the Koreans.¹⁷

Thus the battalions, the hospitals, and the medical group had ample opportunity to gain new combat experience. As the ROK Army medical service became overburdened, evacuees were diverted into American channels. A new kind of helicopter evacuation played its part during the last battle. The long-desired Army H-19 cargo helicopters had arrived in Korea during the spring of 1953. Large machines intended to provide short-haul transport for men and supplies, the H-19s were under the control of transportation companies but carried wounded on return flights. Despite the fact that evacuation was only a secondary mission, the 6th Transportation Company carried 701 casualties between March and the end of the fighting in July, and the 13th Transportation Company 1,547. In the June fighting the large helicopters proved their value, both coming to and going from the line. Their great advantage lay in the fact that the wounded could receive medical attention in flight, which was difficult at best in the little H-13s where patients were carried outside on litter racks. This was an innovation whose significance to future medevac missions transcended its brief use in Korea.¹⁸

Operation LITTLE SWITCH

The most important activity of 1953 in Korea took place at Panmunjom, where major international changes began to register in a series of breakthroughs toward peace. In the United States a new administration warned of severe consequences, including the possible use of nuclear weapons, if the Communist nations did not agree to end the conflict. In the Soviet Union the death of Joseph Stalin in March signaled a power struggle over the succession. Under the circumstances the burden of Korea was one that none of the parties to the war, except some of the Koreans themselves, wished to bear any longer.¹⁹

The first breakthrough was one in which medics were particularly interested: the decision announced by the Chinese and North Koreans on 28 March to agree to U.N. proposals for the exchange of sick and wounded POWs. As worked out between the negotiators, the United Nations was to return 700 Chinese and 5,100 Koreans, or 4.5 percent of the 132,000 prisoners then in its

¹⁷Copy of Article, Lt Col Spurgeon H. Neel, Jr., "The 30th Medical Group in Korea," HSF (Neel Articles), HRB; Hermes, *Truce Tent and Fighting Front*, pp. 459-76.

¹⁸8086th Army Unit, "Helicopters in Korea," pp. 39-40, 48, 155, RG 319, MMHB.

¹⁹Goulden, *Korea*, pp. 548-650.



WARD 236 AT TOKYO ARMY HOSPITAL ANNEX, *where staff and ward attendants await returnees*

custody, and the Communists 450 Korean and 150 non-Korean POWs, or 5 percent of the 12,000 men whom they held. The agreement provided for the exchange to take place at Panmunjom and allowed the Communists to move the wounded to the front in well-marked convoys over designated routes.²⁰

Planning by the United Nations for the exchange had begun too early and, perhaps in consequence, became far too elaborate. The start of peace talks in mid-1951 provoked the first efforts. The Far East Command had decided then to evacuate all prisoners to Japan through medical channels and, after processing, by airlift to the United States. The subsequent course of the truce talks did little to encourage hopes that either plans or planes would soon be needed. The first look at the problem did, however, identify the basic aims of the medical processing: to detect the prisoners' physical problems in order to provide proper treatment; to prevent the spread of communicable diseases from former POWs to others in Japan and the United States; to accumulate medical data for future analysis; and to provide a permanent record of the individual returnee's medical condition for his own and the government's future protection in event of claims. Plans were, according to the command "drafted, revised and redrafted" and

²⁰On the general story of LITTLE SWITCH, see Hermes, *Truce Tent and Fighting Front*, pp. 412-19.



LEAVING FREEDOM VILLAGE ON AN H-19 HELICOPTER

conferences were held “at which myriad problems were discussed.” How much all this bureaucratic buzzing had to do with the ultimate welfare of the prisoners remains unclear.²¹

Activity continued during 1952. Despite the lack of any clear idea of how many prisoners might still be alive in Communist hands, analyses continued on such questions as how many spaces on airlift planes should be allotted to them. A detailed plan based on the 1951 discussions was prepared, submitted, and approved. International Red Cross teams joined in devising schemes for properly feeding the returnees, and the round of conferences on the subject continued at the Far East Command among its staff sections, the technical services, the Air Force, various medical services, the Plans and Operations Division, and the Medical Section’s Preventive Medicine Division. Under these circumstances the extremely small numbers of returnees promised by the Communists—most U.N. POWs had been captured between July 1950 and July 1951 and most of the wounded had either recovered or died—gave the operation dubbed LITTLE SWITCH the look of a barrage of organized compassion aimed at a mouse. Some

²¹Quoted words from FEC, Annual Report of Medical Service Activities, 1951, p. 119, file 319.1-2 (FEC) Far East-1951, HRB. See also *ibid.*, pp. 120-23, HRB; JLCOM, Report of ETMD, December 1951, pp. 28-29 and encl. 10, file 350.05 (ETMD, Far East, JLCOM, 1951), Box 1 (ETMD, JLCOM, 1950-53 . . .), Entry 54B, RG 112, MMFB.

2,248 quarts of reconstituted milk were flown in to provide milkshakes, and the 45th Surgical and 121st Evacuation Hospitals set up to treat the wounded. In Japan the Tokyo Army Hospital and the United States Army Hospital, 8167th Army Unit, were designated to receive the non-Koreans. The H-19 cargo helicopters stood by to fly the POWs from the reception point, Freedom Village at Munsan, to the airport at Seoul. A horde of interrogators and counterintelligence agents waited, with a larger horde of newsmen.²²

By 20 April, the day fixed for the opening of LITTLE SWITCH, the following situation existed. A KCOMZ medical team waited at Panmunjom. Three ambulance companies were ready to evacuate the first POWs to Freedom Village, 15 miles down the Munsan road, where a processing center staffed by marines was set up, with a Navy surgeon in attendance. Nearby, the 45th Surgical Hospital, with two H-13 helicopters, stood in readiness for emergency cases. On a landing pad at the south end of the hospital the first H-19 helicopter waited to carry patients onward to the 121st Evacuation Hospital at Yongdung-po, where guards, litterbearers, and ambulances stood ready to rush patients to treatment. At Yongdung-po, as at Freedom Village, adjutant general personnel prepared to process the returned soldiers and counterintelligence agents to screen them from unauthorized contacts with the press, to fingerprint them, and to confirm their identities.

Into this situation walked, or were carried, the first "packet" of fifty prisoners at 0600. Processing and loading at Panmunjom took about forty-five minutes. Because their condition was better than expected, the medical team at the exchange site took only the litter patients, four in number, and placed a call for the H-13s to pick them up. Eight ambulances left for Freedom Village with the rest. In Munsan the ambulances carrying ROK Army patients turned off to the ROK 5th MASH, while the others moved on to the U.N. processing center.

At the 45th Surgical Hospital an array of brass—Generals Clark and Ginn and the Eighth Army commander, General Maxwell D. Taylor—were on hand to meet each helicopter with the litter patients. Other dignitaries from USAFFE and the Eighth Army command milled about as well. After arriving at the Freedom Village processing center, returnees who could walk had their first physicals and then had their identities verified. Chaplains provided spiritual comfort. When they passed on to the 45th, the men filled out new medical forms and underwent thorough physicals. They then were led in sixes to the landing pad, where they boarded helicopters, and twenty-two minutes later they arrived at the 121st Evacuation Hospital. The men already had changed clothes once, from new attire the Communists had issued them in anticipation of their release to fresh dress uniforms (ODs). Now they doffed their ODs, put on pajamas, and took another physical. Adjutant general and counterintelligence personnel took over again, doing new records checks and reconfirming identities. A few returnees had had brief interviews with the press at Freedom Village, but most were held incommunicado to prevent leaks of any useful information they might have about the enemy. In some cases agents went so far as to accompany them to

²²Daily Journal, Plans and Operations Division, Medical Section, FEC, 4 Jan 52, sub: Air Lift Bricks, pt. 2, item 6, Staff Section Report, Medical Section, FEC, 1-31 Jan 52, file January 1952, Box 3488 (Medical Section, Unit History, Military History Section, FEC, 1952), RG 338, MMFB; EUSAK, Annual Report of Medical Service Activities, 1953, p. 7, HRB.

the showers. Even their diet gave evidence of a somewhat excessive concern, for it was served without salt, apparently in the belief that salt would increase the nutritional edema that they were expected to have. Fortunately, most appear to have spent only thirty-six hours in processing before their planes left for Japan.

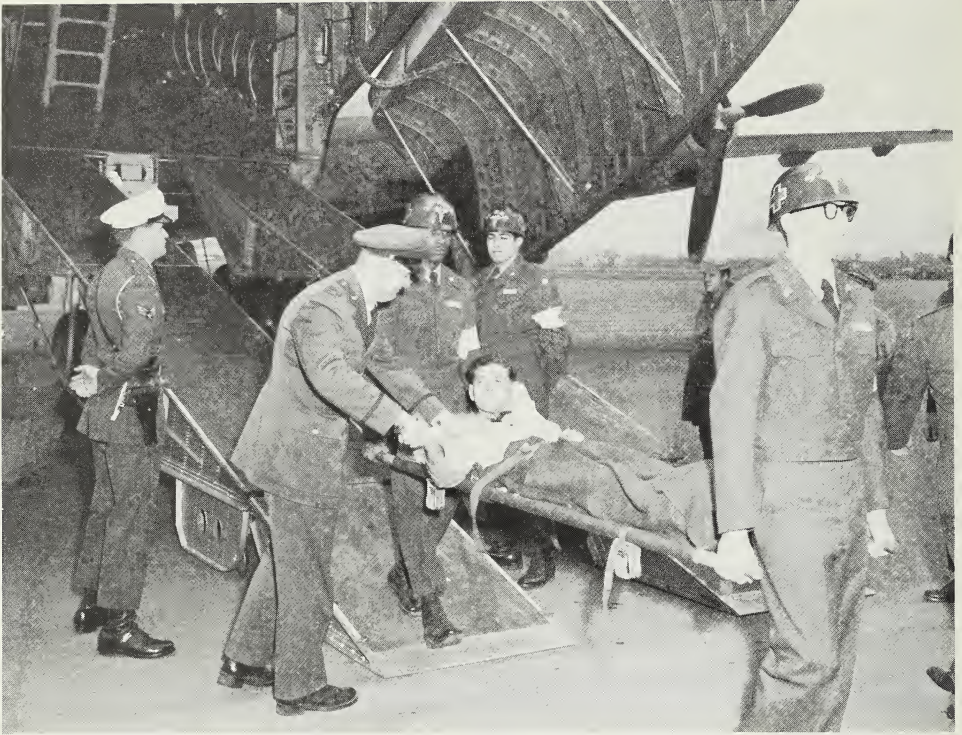
In plain fact, the medical aspect of LITTLE SWITCH was a dull affair. Everything went smoothly, and even giving the men three physicals and forcing sequential changes of attire upon them did not suffice to keep the medical personnel busy. Initial evaluations showed the POWs to be in better shape than expected, and the work resolved itself into routine poking and prodding and the filling out of forms. The process was tedious, and some surgeons, finding nothing to do, departed. The emergency team at Panmunjom was almost without a job. In the midst of this overproduced affair the prisoners themselves impressed most of their interviewers as stolid, except for their enthusiasm for food. The curiously "flattened" personalities of those imprisoned for an extended period were noted; these men answered when spoken to, volunteered nothing, and showed little emotion. Men more recently captured retained their natural spontaneity, reacting emotionally to the sudden release of tension after doubts that had continued almost up to the last moment as to whether or not their captors actually would release them. The old hands continued to act as they had learned to do in order to survive, going through the routine like sleepwalkers not yet awakened.²³

In Tokyo the interrogations got serious. With no medical personnel among the returnees, medical intelligence was necessarily limited. The Far East Command's G-2 (intelligence), however, had many questions. Sessions ran from before breakfast until after supper during the returnees' whole stay in Tokyo. Different intelligence teams had failed to coordinate their questions, and as a result the men were asked many of the same questions over and over. The similarity between this process and what the men had experienced during their captivity provoked resentment, increasing uncommunicativeness, and suspicion as the process wore on. At the same time, new and even more thorough medical testing proceeded for the seven to ten days that they lingered in the Japanese capital. The 147 Americans who passed through this gauntlet showed, on the whole, surprisingly good health. Weight loss was great, ranging from 18 to 46 pounds depending on build, and about 38 percent had parasites of one kind or



ANOTHER CHANGE OF CLOTHES

²³8086th Army Unit, Military History Detachment, "Operation LITTLE SWITCH," vol. 2, "Medical Processing and Evaluation of Repatriated Prisoners," Ms no. 8-5.1A DQ, RG 319, MMHB.



GREETING A LITTLE SWITCH RETURNEE AT TACHIKAWA AIR BASE

another. But few had tuberculosis or malaria, and 8 out of 10 were rated as showing good mental health and morale. Only about 1 percent was diagnosed psychotic. As with recovered prisoners of the Japanese during World War II, the stresses of captivity would show up for many only after a lapse of time.²⁴

The contrary movement of Communist POWs from the hospitals to Panmunjom was a far noisier and more exciting affair for all concerned. To quell new demonstrations as they broke out, guards warned the POWs that they would lose their chance of repatriation. Prisoners riding from the island camps to landing craft for transport to the mainland threw away their rations of soap and tooth powder and tossed away cigarette packs containing hand-printed messages that accused the United Nations Command of “babarous acts.” Some went on hunger strikes; many mutilated their clothing to make themselves look maltreated. On the whole, the command—and especially the prison hospitals—benefited by the departure of the 6,670 sick and wounded prisoners. The gain of 684 assorted U.N. POWs in return may have saved some lives, but the exchange was most important as the first firm step on the road to peace.²⁵

²⁴Reister, *Battle Casualties and Medical Statistics*, pp. 87–91; USAFFE, *Annual Report of Medical Service Activities*, 1953, pp. 62–79, HRB.

²⁵Hermes, *Truce Tent and Fighting Front*, pp. 415–16 and 419. Both sides turned up additional sick and wounded in the process of exchange, and both returned more than originally promised.

Operation BIG SWITCH

In accepting the United Nation's call for an exchange of wounded POWs, the enemy also had suggested that the larger prisoner-of-war issue might be resolved. A few days after the 28 March breakthrough, Chinese Foreign Minister Chou En-lai amplified his first delphic proposal by suggesting that nonrepatriates be turned over for a time to a neutral state to ensure that coercion played no part in their decision not to return home. The negotiations, which had lapsed in October 1952, began again on 26 April 1953. By the middle of June—when negotiators had ironed out all essential disagreements, when the neutrals had forwarded their acceptances, and when staff officers had defined the limits of the Demilitarized Zone that was to separate the armies (*see Map 9*)—the Chinese launched their last offensive.



ENEMY CAPTIVES GOING HOME

The objectives of the Chinese were to strengthen the Communist positions; to give the impression of a victory for their side; and, after Rhee had released the Korean nonrepatriates, to sound a warning to the South Korean government. Thus almost until the last moment, the armies exchanged blows and wounded flowed as before through the medical system. Only in the week before the armistice was signed on 27 July did the fighting wind down. Then followed a great movement of prisoners—repatriates toward home and nonrepatriates toward the Demilitarized Zone for the period of internment and second thoughts allowed by the armistice document. Americans called the return of their own men Operation BIG SWITCH.

Modeled on Operation LITTLE SWITCH, the new exchange went about as smoothly and with considerably less disproportion between the numbers of returnees and of those assembled to receive them. The H-19s, having proved themselves, were called upon once again and performed excellently, moving nine times as many people in seven times as many hours as before. All the returned prisoners were bathed, deloused, and vaccinated against smallpox. One thing that immediately became clear was that not all the sick and wounded had returned during LITTLE SWITCH. Some new returnees arrived with such patent conditions as chronic coughs, amputations, amebiasis, mental illness, epilepsy, cold injury, and malaria. Some of them believed that the Communists had chosen the “progressives,” whether sick or well, to go first.²⁶

²⁶Rpt, Grant, sub: Operation BIG SWITCH, file 383.6 (Operation “Big Switch”) 1953, HRB. In all, 1,132 Americans of the 3,596 included in BIG SWITCH returned home in patient status, but this

(Continued)



MAP 9



**BIG SWITCH RETURNEES ARRIVING
AT FREEDOM VILLAGE**

The stream of men divided, the healthy parting from the sick. American POWs who were well enough were flown by helicopter to Inchon, where they boarded ships for home. Those who required emergency treatment were flown to Japan, where they underwent a week to ten days of medical processing like that of the LITTLE SWITCH returnees. A total of 438 POWs, of whom 345 were soldiers, were judged in sufficiently serious condition to warrant immediate return to the zone of interior. The rest joined other returning ex-prisoners and rotating troops on troopships or hospital ships. (On the former, patients were treated in sick bay.) Accompanying the returnees were USAFFE medical teams—sixteen officers and sixty-two enlisted men for a troopship, eight officers and twenty-

six men for a hospital ship—that were to care for them, finish their processing, observe the psychiatric cases, and extract medical intelligence.

On shipboard the former POWs tended to keep together, believing that those who had not undergone their experiences would not understand them. But the factions of the prison camps endured also, the “progressives” keeping themselves apart while providing interested psychiatrists with voluble explanations of their conduct. There were some fistfights between those who had gone too far along the road marked out by former captors and those who had resisted, but apparently no very serious clashes.

As the process went forward, interrogators recorded in casual fashion a cross section of the varied POW experience. Many men named as their chief physical problem during captivity the pervasive dysentery and gastric complaints caused by coarse and unfamiliar food. “Stomach trouble right along,” said one, “rough chow had tore my insides.” Most had received medical care from their captors, though it was often crude and unskillfully applied. Of those who were treated with acupuncture, a few seemed uncertain whether this was a form of medicine or an oriental torture.) Exercise and recreation had been surprisingly abundant

(Continued)

status was not always deserved. See extract from Medical Plans and Operations Division, OSG, Annual Historical Report, 1 Jul 53–30 Jun 54, tab N, “Summation of RECAP-K Operation,” HSF (RECAP-K Operation), HRB.

in the camps. An Air Force staff sergeant recalled "cards, ping pong, basketball, volleyball, softball, chess pieces made by PWs—All male square dances."²⁷

But many also had harsh memories of interrogation and abuse. A Mexican-American sergeant first class was hung from the ceiling by his arms for nine hours and put to hard labor because of his "hostile attitude toward the Chinese Peoples Volunteers." Those who attempted escape spent months in "the Hole," typically a cold bare room with "unplaned knotted floor." A young airman recalled that "the most common form of punishment for breaking camp rules was standing at attention for hours. In the winter time punishment might be standing at attention in your bare feet upon a cake of ice and holding a snowball in each hand."

Some appeared to have gone through their ordeal without injury and with little inner turmoil, like the sergeant who "made no escape attempts, got into no fights and had no special punishments." In this case indoctrination "went in one ear and out the other." A black GI underwent "considerable indoctrination" but said the appeals emphasizing American racism had little influence on him because he was "pissed off" at the treatment he had received from the Chinese. Men of the most varied experiences, however, reported one reaction in common: Many had cried at Freedom Village.

Once in the United States, patients needing immediate specialized treatment followed men from LITTLE SWITCH into Army hospitals. As many as possible were placed on leave. Those neither in a dangerous condition nor well enough to visit their homes at once were sent to the hospital nearest home, where their families and friends could visit them. Hawaiians went to the Tripler Army Hospital, Filipinos to Manila, and Canadians to the Madigan Army Hospital for transfer to their own country. Of the BIG SWITCH returnees 4 percent showed signs of tuberculosis, about 2 percent had malaria, 16 percent were suffering from malnutrition, and less than 3 percent were neuropsychiatric casualties. None had any other major infectious diseases, for which the systematic inoculations introduced by the Chinese in 1952 probably must be credited. The lack of serious malnutrition cases reflected the better diet that most had received during 1953. The overall physical condition of the U.N. POWs who survived can be summed up as not too bad, everything considered.²⁸

The worst consequences of captivity for most surfaced only after a lapse of time. Though the concept of posttraumatic stress disorder had not yet received clinical formulation, the experiences of many former Korean POWs resembled those of World War II survivors of Japanese prison camps. In some respects they were worse. For years after the war former prisoners showed higher death

²⁷Quoted words in this and the following two paragraphs from Repatriated POW Psychiatric Surveys, August–September 1953, Encls to Ltr, Capt William B. Fowlkes, Administrative Officer, Joint Intelligence Processing Board, USAFFE, 1 Oct 53, sub: Reports of Repatriated POW Psychiatric Surveys and Medical Intelligence, file 383.6 (Far East Command) AA, 1953, Box 72, and 6004th Air Intelligence Service Squad, Air Intelligence Information Report nos. RPW 3022B, RPW 3024A, RPW 3522A, RPW 4502, RPW 4516–2, RPW 4523, all 8 Sep 53, file 350.05 (Korea) F, 1953, Box 53. Both Accession no. 56A–179, RG 112, WNRC.

²⁸USAFME, Annual Report of Medical Service Activities, 1953, pp. 9–11; Preventive Medicine Division, OSG, Summary of Major Events and Problems, 1 Jul 53–30 Jun 54, pp. 159–60, file 314.7–2 (Army Medical Service Activities, 1 Jul 53–30 Jun 54). Both in HRB.

rates than other veterans of the fighting. The degree of stress during imprisonment directly correlated to later death, which resulted most commonly from accident, suicide, or homicide. Persistent psychiatric sequelae were noted, including schizophrenia. Nutritional deficiencies endured during captivity showed up later as an apparently permanent susceptibility to tuberculosis and to other infectious and parasitic disorders.

Complicating a difficult homecoming for POWs were attacks by their own countrymen. Arguing that Americans had become too soft and slack to meet the challenge of Communist aggression, energetic charlatans of many stripes spread the legend that American prisoners during the Korean War had been uniquely spiritless, dying without cause and yielding without reason to enemy pressures. Men who already had suffered much faced an ordeal at the hands of some fellow Americans, which contrasted sharply with the lavish care that had attended their release.²⁹

After the Battle

As the guns fell silent, peace came to the Medical Service in varied and sometimes paradoxical ways. At the hospitals of the 30th Medical Group only a temporary decrease in admissions was noted. Instead of hurriedly giving emergency treatment and evacuating the wounded, the surgeons at the forward hospitals screened personnel in the units they served to locate those who were in need of elective procedures—correction of hernias or hemorrhoids, circumcisions, and so forth. In the more relaxed atmosphere of the postwar hospitals, patients already on hand also were treated for retained foreign bodies and the like. Hence, the impact of peace showed most noticeably in reduced evacuations rather than in a declining hospital census. In the 2d Infantry Division, Medical Corps officers moved out of the aid stations, which Medical Service Corps officers now could handle adequately. Training increased, with refresher courses taking the place of the wartime influx of wounded in reminding Medical Service personnel of the basics of their profession.³⁰

A major innovation for improving the skills of enlisted medics was the establishment under the 30th Medical Group of the Eighth Army Medical Training Center, located immediately to the rear of the IX Corps area at Chongpyong-ni. The first class opened on 26 October 1953 and soon specialized training was under way on a three- to four-week cycle for aidmen, corpsmen, and technicians of various types. Classes were small, most of the instructors medical officers from the 30th Medical Group, though two Medical Service Corps officers and two Army nurses were on the faculty. Bivouac and unit

²⁹Biderman, *March to Calumny*, passim; M. D. Nefzger, "Follow-up Studies of World War II and Korean War Prisoners, I: Study Plan and Mortality Findings," *American Journal of Epidemiology* 91 (February 1970): 123-38; G. W. Beebe, "Follow-up Studies of World War II and Korean War Prisoners, II: Mortality, Disability, and Maladjustments," *American Journal of Epidemiology* 101 (May 1975): 400-22. An interesting recent study of the general topic is Richard H. Rake and Ellen Genender, "Adaptation to and Recovery From Captivity Stress," *Military Medicine* 148 (July 1983): 577-85.

³⁰30th Medical Group, Annual Report of Medical Service Activities, 1953, pp. 4-5, Annex I to EUSAK, same report, 1953, HRB. See also 2d Infantry Division, Annual Report of Medical Service Activities, pp. 2-3, file 319.1-2 (2d Inf Div) Far East-1953, HRB.

training accompanied classwork, providing a well-rounded curriculum of theoretical and field instruction.³¹

Other signs of the times included a construction program during the second half of the year aimed at replacing tents with semipermanent buildings, both in hospitals and in troop quarters. Men and women who still had to live in winterized tents, however, found the 1953–54 season relatively mild. The troops fared well, and no particular problems arose in keeping them healthy through the cold season. To care for nonrepatriated POWs in the Demilitarized Zone pending their final disposition, the KCOMZ transferred four medical units to the Eighth Army—one field hospital, one clearing company, one veterinary food inspection detachment, and one ambulance detachment. Meanwhile, the Prisoner of War Command closed up shop, shifting its dispensaries to Korea Base Section and inactivating the remainder of its units. As in the forward areas, training activities increased to fill empty time and keep a cutting edge on the skills of the troops.³²

Organized aid to the Koreans as they sought to reconstruct their country developed during the same period under the Armed Forces Assistance to Korea Program. Eighth Army medical units sponsored construction projects and sent Army medical personnel into Korean civil and military hospitals to assist in the care of patients and to aid in the training of doctors and nurses. At the same time, under orders from USAFFE headquarters, Korean health personnel were brought into Eighth Army hospitals for training and civilian patients admitted for treatment. One evacuation hospital reported that it was aiding about a thousand civilians a month in various ways and that its personnel additionally were providing aid and support to an orphanage for refugee children. At Christmas 1953 a Santa Claus from the hospital staff presented gifts: ten bags of rice, 75 pounds of fish, a supply of seaweed, and a truckload of firewood. A pair of socks and rubber shoes went to every child, plus games, candy, dolls, and balloons. Two days later the orphans reciprocated, presenting a dance and music show at the hospital for patients and staff that earned the small entertainers candy and oranges, and for all the children new gifts sent by the fire department of Spokane, Washington. Typical of many such efforts by American units, the work of the 11th Evacuation Hospital was practical and useful, but the oranges and gifts probably remained longest in the memories of the children.³³

At higher headquarters, signs of the changeover to peace were varied: increased indiscipline and violence among idle troops; a temporary overstrength in doctors, which, in a fashion made familiar by the aftermath of World War II, soon changed to a deficiency; hospital closings; and plans for the departure of

³¹Briefing, Lt Col Spurgeon H. Neel, Jr., MC, Commander, 30th Medical Group, to Gen Maxwell D. Taylor, Commander, EUSAK, 10 Nov 53, sub: The Eighth Army Medical Training Center, HSF (Neel-1953), HRB.

³²EUSAK and KCOMZ, Annual Reports of Medical Service Activities, 1953, pp. 1–2 and p. 2, respectively, HRB.

³³11th Evacuation Hospital, Semimobile, Annual Report of Medical Service Activities, 1953, p. 8, Annex II to EUSAK, same report, 1953, HRB. Other useful reports for 1953 are those of the KCOMZ and the 121st Evacuation Hospital, Semimobile, both at HRB. See also Msg no. EX 24164, CG USAFFE to CG EUSAK, 14 Oct 53, file 701 (Far East Command) AA, 1953, Box 73, Accession no. 56A-179, RG 112, WNRC.

major units from the Far East Command. Like the planning for the prisoner exchange, plans for the postwar drawdown went back to the days of 1951, when the truce talks were new and peace had seemed close at hand. Planning continued in more elaborate fashion during 1952 and became a large part of the work of the Plans and Operations Division at USAFFE in the following year. Though the nature of the armistice inclined the cautious to delay major deployments until the completion of a less tentative settlement, readjustments began at the end of the summer. One convalescent hospital was closed, operating beds were reduced from a bit over ten thousands to about eighty-six hundred throughout the command, and a portion of the Tokyo Army Hospital was shut down. However, the armed peace that had come to Korea did not encourage hasty action, and USAFFE did not contemplate reducing the hospitals available to the military in Korea, where they might be needed at any time. The Korean Civil Assistance Command, the Republic of Korea, and the Japanese government all had their eyes on American military hospitals, but no general transfer of facilities occurred in 1953, and the year ended with the medical establishment largely in a holding pattern.³⁴

Overall, the post-Korean War Medical Service began to show a marked similarity to the earlier postwar period of 1945–50, though maintenance of the general draft ensured that personnel levels would not again sink so low. The doctor draft resulted in an overstrength in medical officers during the July–September quarter in 1953. The American Medical Association complained, and the old problem of underuse of doctors again alarmed the Office of the Surgeon General. Similarly, the influx of many board-qualified or board-certified specialists raised the usual difficulties in assigning them to posts that were suitable to their skills. Personnel losses in the Medical Service Corps and Army Nurse Corps resulted in a lower authorization from the Army's G-1 (personnel), with line officer benefiting from the transfer of two hundred to three hundred slots that the Medical Service could not fill anyway. Analysis suggested that about one-third of the Medical Service Corps would turn over during fiscal 1954, and hospital commanders in the zone of interior were urged to "get any really capable warrant officer or enlisted man" to apply for a commission, because civilian college graduates who agreed to join probably would leave after fulfilling their minimum time of service. In searching for nurses the old litany of expedients was drawn up again, with complaints from nurses already serving about work load, nonprofessional duties, and, above all, the length of overseas tours and the wish of many to marry and accompany husbands. While standing firm against commissioning male nurses in the Regular Army, the surgeon general backed the notion of offering such men reserve commissions, but the year ended with Congress' views still uncertain.³⁵

³⁴USAFFE, Annual Report of Medical Service Activities, 1953, pp. 80–86; JLCOM, Annual Report of Medical Service Activities, 1952, pp. 97–99, file 319.1–2 (JLCOM) Far East–1952. Both in HRB.

³⁵Summary of Presentations and Discussions at the Conference of Army Surgeons and Class II Hospital Commanders, Held in the Office of the Surgeon General (Room 3601, Main Navy Building, Washington, D.C.), 5–6 Nov 53, p. 85, file 337 (Army Surgeons and Class II Commanders) 5–6 Nov 53, HRB.

As the draft calls fell and the emergency passed into the uneasy peace of the central Cold War, the problem of getting sufficient doctors for the Army again appeared, with all its customary train of subsidies, appeals, and administrative tours de force. Plans for scholarships, affiliated units, hiring of contract physicians, and the use of civilian consultants as emissaries to the civil profession of medicine all continued as in the past, or resumed shortly. Existing Regular Army slots could not be filled; about two-thirds of the Medical Corps consisted of draftees who had accepted reserve commissions for a two-year tour of duty. At the end of 1955 an officer briefing the surgeon general spoke like an echo of the past: "One of the most serious matters facing the Army today is the problem of providing an adequate medical service. The crux of this problem is the critical shortage of Medical Corps officers."³⁶

Another difficulty resulted from a decision of the secretary of defense in May 1953 to prescribe a ceiling for the armed forces of 3 doctors per 1,000 troop strength. This rigid requirement did not become fully operative until mid-1954 and thus did not affect the Korean War. It was, however, a new source of old woes thereafter, especially for the Navy, which had the highest existing ratio (about 4 doctors per 1,000 troops, as compared to the Army's 3.5). The number of units and their makeup and distribution, the number of dependents, and the number of hospitals and their size were some of the elements that determined the true needs of the services. The new rule, which the Department of Defense adopted in response to pressure emanating from the White House, may properly be termed a political decision. In setting up the doctor draft, Congress had provided for the creation of a Health Resources Advisory Committee in the Executive Office of the President to enable civil medicine to influence draft policy. At a time when the president of the American Medical Association warned that the United States had "25% more practicing physicians in proportion to population than any other country in the world," and that physicians were increasing faster than the population, the advisory committee wrote a presidential assistant to ask that the number of military physicians be reduced. The "*continuing withdrawal of physicians for military duty*," it warned, was having an "*increasingly serious impact . . . upon civilian medical services*." Residencies in civilian hospitals were said to be going empty, or being filled by "aliens, with all that implies in the way of possibly inferior training and of language difficulties." The committee also pointed out, in what probably was the true crux of the matter, that exhaustion of the former Army Specialized Training Program graduates and other younger physicians might soon require older men with established practices to serve. It therefore recommended the 3 to 1,000 ratio, a suggestion that the Defense Department was quick to adopt.³⁷

³⁶Copy of Briefing, 1 Dec 55, on historical background and present difficulties of medical officer procurement, in HSF (Briefing-1955), HRB.

³⁷Quoted words from copies of Memo, Howard A. Rusk, M.D., Chairman, Health Resources Advisory Committee, to Arthur S. Flemming, Acting Director, Office of Defense Mobilization, 29 Jan 52, and Ltr, Flemming to Charles E. Wilson, Secretary of Defense, 29 Jan 53, Cut in Ratio of Military Doctors, 1953-54, file, Box 7 (General Green's Office-Reference File), Accession no. 112-79-5, RG 112, WNRC. Some physician shortages existed in rural areas, but there seems no reason to believe that discharged medics would migrate to such regions to fill them. See also copy of Briefing, 1 Dec 55, HRB.

The difficulties of the post-Korean War Medical Service were much the same as in the past. The United States continued to offer its doctors monetary rewards, specialized training, personal distinction, and—above all—ideals of individual freedom and choice, which were beyond the ability of the Army to match. Even with a draft in place, the civilian profession fought for the retention in service of the smallest number of physicians deemed capable of doing the job, and the Medical Service, among an abundance of talent and training without equal in any other society in the world, provided for the Army with whatever it could get. *Plus ça change.*

Civil Assistance Revisited

Meanwhile, the emergence of the new-model Korean Civil Assistance Command (KCAC) signaled a major shift from emergency relief to reconstruction for the battered Republic. Here, as in the days of the fighting, much of the work to be done was medical. The United Nations Command's economic coordinator, C. Tyler Wood, decided to avoid excessive duplication of effort in Korean relief and divided responsibilities for specific fields between KCAC and the United Nations Reconstruction Agency (UNKRA). The Army command received the Korean public health program as its bailiwick and thereafter functioned as the operating agency, regardless of the source of funding. The command's Public Health Branch under Col. James P. Pappas continued to work with the mixed staff of civilian and military personnel and American and U.N. experts gathered under its predecessor, the United Nations Civil Assistance Command, Korea (UNCACK). But now the branch could use the funds it received from an array of sources—from Civil Relief in Korea (CRIK), from Washington's newly established Foreign Operations Administration, from UNKRA, and from direct military support—for the long-term rehabilitation of Korea's medical and health system.³⁸

The new approach represented a considerable broadening of the wartime goal of preventing disease and unrest. Tyler Wood emphasized that the new approach featured the transformation of Korea not only into a military bastion but also into a showcase of progress for the American-led anti-Communist coalition:

We have an opportunity in our work in Korea on the economic side to affect the situation in this struggle between the free world and the communist world, not only in Korea, but certainly throughout the Far East. I would make bold to say, throughout the world. The two systems are facing each other on trial here. If we can show, in cooperation with the brave people of South Korea, who have already proved their courage on the battlefield, that the kind of conditions we stand for in the free world can be created here, and if we can show in comparison with conditions across the border the advantages of

³⁸Information on the Korean Civil Assistance Command, unless otherwise stated, is from its Annual Report of Public Health in Korea, 1953. The Foreign Operations Administration was set up in August 1953 under Harold E. Stassen, a perennial candidate for the Republican presidential nomination, to coordinate all foreign assistance activities.

our system and our freedom, it seems to me it will not only have a real effect in South Korea, but throughout the Far East.³⁹

Corollary to the ideological thrust was a practical objective—enabling the Koreans, by developing a modern economy, to reduce American subsidies and to take on the burden of their own defense. The contrast with the situation in 1945–48 was striking. Then the Army had struggled with insufficient means in a backward nation that had been spared the worst ravages of war. Now, with thirty-three thousand dead invested in South Korea's freedom, and with the Cold War deeply embittered by the blood shed there, the United States and its allies in the United Nations were ready to supply more adequate means in order to advance the continuing world struggle. These too were consequences of the war that had destroyed the nation's modest advances, killing several million of its people and laying waste much of the physical substructure of civilization.

The end of the fighting made more military personnel available for civil relief and especially aided the Public Health Branch, where, in the days of UNCACK, extreme shortages were the rule. KCAC, however, retained the international flavor of the earlier effort. UNKRA doctors headed the preventive medicine, medical care, nursing, and environmental sanitation sections and all the field teams that assisted the various provincial governments.

The conditions faced by these men and women—women filled all the nurses slots, one physician's slot and also served as secretaries, typists, and administrative assistants—remained difficult even though the war had ended. Public health competed within the South Korean government for limited funds against a host of other, and apparently more urgent, needs for defense and reconstruction. For fiscal year 1954 the nation's total public health budget was \$3.5 million, or about \$0.16 per capita, as against \$0.50 to \$0.75 recommended by outside experts and the World Health Organization. The subsidy in kind embodied in CRIC medical supplies left a deficit of several million dollars between appropriations and need and provided no assistance to the starveling salaries of Korean public health workers. (The minister of health earned an estimated U.S. equivalent of \$43 a month, a nurse \$11 a month.) An invitation to official corruption, such pay scales also ensured that abler people would evade government service. Doctors, for example, continued to migrate to the large cities where a physician reportedly could earn in a day ten times what a government official took home in a month.

Essential tools of public health management, if they had ever existed, vanished with the war. Vital statistics were hard to come by. Colonel Pappas, remarking that by official figures South Korea had a lower death rate than the United States, ruled that "no cognizance [should] be taken of these data." Most of the meager funds available were spent on the care of lepers—probably a reflection of the interest traditionally felt by Christian missionaries in this biblical plague—and of war casualties. Yet the country established its first school of public health in the fall of 1953, and Pappas discovered what he called "bamboo roots" support for public health among the people at large, whose

³⁹*Ibid.*, p. 11.

demand for health services ranged far ahead of the government's ability to provide them.⁴⁰

The thrust of KCAC endeavors was necessarily varied in a situation where very little was adequate and, in consequence, where everything must be done at once. However, the endeavor to control disease and upgrade health care and the medical professions were certainly basic. Among the major diseases, smallpox remained endemic and had become largely a disease of childhood. The across-the-board vaccination campaign among refugees therefore gave way to a concentrated effort to immunize the young. Using CRIK-bought vaccine, South Korean personnel carried out five million vaccinations in the last quarter of 1953. Plans called for administering two million additional doses during the first half of 1954 and, in the spring and fall, regular boosters to preschoolers who were the last large susceptible group in the country. South Korean government and KCAC-UNCACK figures differed widely, with the latter reporting that 1953 had seen both the incidence of smallpox more than double the 1952 rate and the number of deaths rise from 251 to 470. Either statistic was a far cry from the epidemics of 1951, when UNCACK had estimated over 5,000 deaths and the South Korean Ministry of Health nearly 12,000. The first months of peace suggested the possibility of a future Korea that would be substantially free of the illness, like other modern nations.

With improved water supplies, immunization and health education, typhoid and paratyphoid continued to fall during 1953, when only 79 deaths were recorded by KCAC and 333 by the South Korean government. The number of deaths from diphtheria was low for the year, at 43 nationwide, but parental resistance, for obscure reasons, made it less easy to inoculate children against this disease than against smallpox. Malaria was a particularly difficult question. It was not a reportable disease, and the almost 14,000 cases and 2 deaths reported by KCAC probably had little or nothing to do with its actual prevalence. No dependable data were available on dysentery, either, though the command noted 19 deaths and over 8,000 reported cases.

Above all, tuberculosis remained a statistical enigma. Some 6 percent of the population were believed to have the illness in more or less serious form, nearly 1.3 million people in all. Budgetary constraints made the increase of hospital beds for tuberculosis patients slow, and the operations of the Korean draft and lack of money to pay workers disrupted a program to inoculate the young. But 1953 at least saw an apparent breakthrough in public interest. The ROK Army made plans to X-ray its troops and screen recruits, and the South Korean government established a National Tuberculosis Association to raise funds for public education and a pilot control center. CRIK funds bought Japanese-made tuberculin for a thorough study in Pusan orphanages carried out by the Swedish Red Cross Hospital. (Almost 16 percent of the children tested had active tuberculosis.) The year's work seemed to point toward a more systematic approach to a problem whose solution, if any, still lay in the distant future.

Programs to improve care included CRIK and UNICEF contributions to maternal and child health care programs; supplying additional equipment to

⁴⁰*Ibid.*, p. 1.

national, provincial, and city laboratories; enforcement of quarantine regulations upon American and U.N. nations ships by the Korea Base Section surgeon; and aid to the National Vaccine Laboratory by the 406th Medical General Laboratory in Japan. The Italian Red Cross Hospital at Yongdung-po continued to function as the only U.N. forces hospital under KCAC, caring for thousands of civilian patients during 1953. KCAC also assisted voluntary agencies that had taken an interest in Korean relief—religious groups, the International Red Cross, the American-Korean Foundation. It sought to upgrade medical education and to bring nursing education back into the path of systematic professional improvement that was under way during 1945–50. Extending the list of KCAC endeavors only would underline the point that many improvements had to be made at once and that supplies of money and especially of trained personnel, though greater than during wartime, were still inadequate to accomplish the job.

One thing was clear, however. The war had awakened a worldwide interest in Korea that had never existed before. Nations that had expended blood and treasure there—especially the United States—now could not abandon the people whose fate had so unexpectedly become entangled with their own. Outside intervention had divided Korea and provided the basic cause of the war that had leveled the country. Now many of the outsiders who remained were building and curing, teaching and administering, giving money, advice, and time to the process of reconstruction. With such aid the Korean people over the next generation would build a progressive economy and a small, provincial, but modern country out of the ruins. The Hermit Nation had become a crossroads, and in 1953 KCAC was for the time being at the center of the international effort to remake Korea in the field of public health.

The Korean Experience

For the medics who served, the Korean War provided extraordinarily diverse experiences. Aid station and general hospital, refugee camp and prison, death march and child care clinic—the faces of wartime medicine were endlessly varied. Over the war years the strength of the Army rose from under 600,000 to almost 1.5 million. Strength in the Far East went from 148,000 to 510,000. To serve this swelling array, the Medical Service relied upon a smaller number of medical units than normally would have been available. The 750-bed evacuation hospital, normally the large backup unit to the 400-bed type and the smaller field and surgical hospitals, never appeared in Korea. Instead, a unique system evolved from the objective facts—the paucity of medical personnel when the war began; the closeness of Japan, with its existing hospital system; and the availability of air transport. Evacuation took up the slack created by a lack of trained personnel and bed space. Within Korea the helicopter was one of the surprise triumphs of the time, and the MASH worked exceedingly well, though as a flexible multipurpose organization rather than as the specialized T/O&E unit. Many of the successes of the Medical Service in Korea were revivals of



REPATRIATED ARMY DOCTORS SHARING THEIR EXPERIENCE. *Left to right: Capt. Clarence L. Anderson, Capt. Gene N. Lam, Surgeon General Armstrong, Capt. William R. Shadish, Capt. Sidney Esensten, and Capt. Alexander M. Boysen.*

World War II practice, notably in the blood program and in combat psychiatry. Basic military surgical techniques, like debridement and delayed closure, had to be relearned again and again as new generations of surgeons arrived in the Far East.

Korea also registered the advances of medicine since World War II, and made contributions of its own to organization and clinical practice. Neurosurgical injuries were managed with unwonted skill. An array of antibiotics aided all medical endeavors. The early repair of vascular injuries by grafts and other means not only had a lifesaving function but also provided experience of considerable research value, because such injuries were comparatively rare in civilian practice. The kidney machine received an important field trial. Shock was better understood, and the plasma expanders introduced in World War II were used widely and with success. With its helicopters and ambulances, radio dispatcher system, and shock treatment facilities, the MASH gave a foretaste of the emergency medicine of the future.⁴¹

⁴¹Copy of Rpt, Lt Col Spurgeon H. Neel, Jr., MC, Commander, 30th Medical Group, September 1953, sub: Significant Lessons Learned in Korea, HSF (Neel-1953), HRB; *New York Times*, 23 Aug 53.

The most striking departure for Army medicine in the prewar years—the residency program with its emphasis on specialization to the detriment of field medical experience—had a mixed record in Korea. Tragic was the situation of young doctors, deficient in all the military arts, who were plucked from comfortable hospitals and thrust into battalion aid stations to organize retreats before a ruthless foe. Often their patients must have paid with their lives (as doctors did also) for the effort of the Medical Department during 1945–50 to follow too closely a civilian model that military medicine could at best only hope to approximate. Yet heightened professional skill meant increased chance of survival for the wounded who reached hospitals. Interacting with the other advantages of the Medical Service in Korea, such skill was essential, especially in the 1950 emergency when drafted doctors were not available and the medics had to live (and save the lives of others) largely by their own resources. How was a military medical organization to be put together and held together in affluent America that had the professional capabilities of the civilian physician, who did nothing else, and the varied soldierly and administrative skills demanded by the battlefield? The question that dominated the years 1945–53 would only be alleviated, not cured, by the continuing draft of young doctors in the postwar years.

As for the men and women who served in Korea, this entire volume seeks to describe their services and achievements, often under most difficult conditions. An array of individual and unit citations recognized the medics at the time, not only for carrying out their professional duties under fire but also for standing beside the line troops in a war where the enemy's indifference to a medical brassard made all perforce into fighters. No less remarkable, perhaps more so for the rarer quality of courage displayed, were the actions of medics who voluntarily remained with their wounded to be captured. In enemy prison camps, lack of medical supplies might make curing impossible, but caring was almost always an option.⁴²

Throughout the medical system the work of many men and women transcended their formal mission of conserving the fighting strength of the Army. Compassion was not the property of any branch or service, but the nature of the medics' task allowed them to embody the compassionate spirit of their people. Any candid history of medicine in war must in great part be a litany of the complicated and awful woes that men inflict upon one another. From it, however, may come a renewed respect for the equally human urge to save and restore war's victims through the healing art.

⁴²See, for example, Medical Company, 223d Infantry Regiment, Annual Report of Medical Service Activities, 1953, Encl to 40th Infantry Division, same report, 1953, file 319.1–2 (40th Inf Div) Far East–1953, HRB; Eighth United States Army General Order no. 81, 14 Sep 51, and General Order no. 696, 15 Oct 54, MMFB; Department of the Army General Order no. 77, 5 Nov 51, General Order no. 102, 21 Nov 51, and General Order no. 104, 5 Dec 51, PAB. No overall count of awards and decorations to medics was found; however, see *Military Surgeon* 108 (May 1951): 438–39 for a partial total. Anyone with the inclination to do so could compile a complete list from the monthly Surgeon's Circular Letters, Medical Section, FEC, on file in HRB.

Bibliographical Note

The Medics' War is based primarily on manuscript sources available in the Washington, D.C., area. A large collection of note cards, either copies of or extracts from official records, is in the custody of the Historical Records Branch (HRB) of the U.S. Army Center of Military History. Prepared by researchers working for the Historical Unit of the Office of the Surgeon General, these cards were particularly valuable because some of the original documents have since disappeared, or have become impossible to trace. (In all cases where I, and my diligent editor, were able to check the cards against the originals, the transcriptions proved to be accurate.)

The records of many medical units for the Korean War period, primarily the Annual Report of Medical Service Activities and the monthly Report of Essential Technical Medical Data, also are housed at the Center of Military History. Here, too, are many ephemeral publications and handouts that played their part in recreating the flavor of the era. At some point in time the center will accession these records to the National Archives and Records Administration in Washington, D.C.

Similar medical reports, generally for the pre-Korean War period but in some cases duplicates and in other cases complementary, and useful letters, memorandums, directives, diaries, and related materials are in the possession of the National Archives' Modern Military Field Branch (MMFB) at Suitland, Maryland. The record groups (RG) for these retired documents are RG 112, Records of the Office of the Surgeon General (Army); RG 153, Records of the Office of the Judge Advocate General (Army); RG 319, Records of the Army Staff; RG 331, Records of Allied Operational and Occupation Headquarters, World War II; RG 338, Records of U.S. Army Commands, 1942-; and RG 407, Records of the Adjutant General's Office, 1917-. At Suitland, too, in the National Archives' Washington National Records Center (WNRC) under the care of The Adjutant General, are the central files of the Office of the Surgeon General, Department of the Army (RG 112), which yielded many valuable insights.

Of considerable importance was a collection of manuscripts written by historical units and detachments during and immediately after the Korean War, now deposited at the National Archives' Modern Military Headquarters Branch (MMHB) in RG 319 and also preserved on microfilm at the Center of Military History. These accounts range from after-action reports to lengthy official histories of various phases of the conflict. Those treating surgical hospitals, helicopters, the care of refugees and prisoners, medical unit actions, and the LITTLE SWITCH-BIG SWITCH operations were especially useful to my own study.

Other materials I would have been hard-pressed to do without include a number of contemporary professional papers on medical subjects, preserved in the Medical Historical Unit Collection of the Archives, U.S. Army Military History Institute, Carlisle, Pennsylvania; the enlightening manuscript autobiography "Medic," kindly supplied me by its author, Brig. Gen. Crawford F. Sams, MC, USA (Ret.) and now in the Center of Military History's Library (LIB); and the forthcoming operational narrative prepared by my colleague, Billy C. Mossman, which in time will join this volume in the center's United States Army in the Korean War series.

Interviews were very helpful in dealing with a war so recent, and I was able to carry out several, notably with General Sams and with John W. Vester, M.D., a former MASH officer. In the 1960s historian Samuel Milner of the Historical Unit of the Office of the Surgeon General interviewed over 150 people who were prominent in military medical affairs during the post-World War II period. Others, in response to his queries, submitted personal narratives of exceptional interest. Unfortunately, the interviews were not taped in most cases, but the interviewer's notes preserve a fund of useful observations by participants, some of whom are no longer living. Now housed at the Center of Military History, these materials will find their way ultimately into the medical collection at Carlisle.

The germ warfare episode sent me to sources that were unfamiliar to me, teaching me a little more about the breadth of materials available in this city. Information kindly made available by the Central Intelligence Agency and the Defense Intelligence Agency was most useful, and the unclassified collections of translated press reports from China and Korea preserved on microfilm at the Library of Congress were of at least equal value. Precise references to these and other sources will be found, chapter by chapter, in the notes.

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List of Abbreviations

ADCOM	Advance Command and Liaison Group
Admin	Administrative
AH	Hospital ship code
AKA	Attack (amphibious) cargo ship code
ANC	Army Nurse Corps
ANCs	Army Nurse Corps officers
AP	Transport ship code
APCs	Armored personnel carriers
ASCOM 24	Army Service Command 24
ASF	Army Service Forces
ASTPs	Army Specialized Training Program graduates
AU	Army Unit
AUS	Army of the United States

BB	Battleship code
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Cav	Cavalry
CHA	Clinical History Activity, CMH
Chem	Chemical
CINCFE	Commander in Chief, Far East
CMH	Center of Military History
CRIC	Civil Relief in Korea

DA	Department of the Army
DC	Dental Corps
DD	Destroyer code
Div	Division

ETMD	Essential Technical Medical Data
ETO	European Theater of Operations
EUSAK	Eighth United States Army, Korea

FEC	Far East Command
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G-1	Personnel section of divisional or higher staff
G-2	Intelligence section of divisional or higher staff
G-3	Operations section of divisional or higher staff
G-4	Logistics section of divisional or higher staff
HRB	Historical Records Branch, CMH
HSF	Historian's source file, CMH
Inf	Infantry
JAG	Judge Advocate General
JLCOM	Japan Logistical Command
KATUSAs	Korean Augmentation to the United States Army personnel
KBC	Korea Base Command
KCAC	Korean Civil Assistance Command
KCOMZ	Korean Communications Zone
KMAG	United States Military Advisory Group to the Republic of Korea
KSCs	Korean Service Corps personnel
LIB	Library, CMH
MASHs	Mobile army surgical hospitals
MATS	Military Air Transport Service
MC	Medical Corps
MCs	Medical Corps officers
MIAs	Missing in Action casualties
MMFB	Modern Military Field Branch, NARA
MMHB	Modern Military Headquarters Branch, NARA
MOS(s)	Military occupational specialty(ies)
MSC	Medical Service Corps
MSCs	Medical Service Corps officers
NARA	National Archives and Records Administration
NPs	Neuropsychiatric cases

ODs	Dress uniforms
OSG	Office of the Surgeon General, DA
PAB	Printed Archives Branch, NARA
PF	Frigate code
POWs	Prisoners of war
Recs	Records
RG(s)	Record Group(s)
ROK	Republic of Korea
ROTC	Reserve Officers Training Corps
R&R	Rest and recuperation
SG	Surgeon General
SCAP	General Headquarters, Supreme Commander for the Allied Powers
Sig	Signal
SOP	Standard operating procedure
SSB	Staff Support Branch, CMH
Surg	Surgeon
T	Military Sea Transportation Service code
TD(s)	Table(s) of distribution
TDY	Temporary duty
T/O&E(s)	Table(s) of organization and equipment
U.N.	United Nations
UNC	United Nations Command
UNCACK	United Nations Civil Assistance Command, Korea
UNICEF	United Nations Children's Fund (<i>Acronym taken from former name: United Nations International Children's Emergency Fund</i>)
UNKRA	United Nations Korean Reconstruction Agency
U.S.	United States
USA	United States Army
USAFFE	United States Army Forces, Far East
USAFIK	United States Army Forces in Korea
USAFPAC	United States Army Forces, Pacific
USAMGIK	United States Army Military Government in Korea

V-12s	Navy Specialized Training Program graduates
VD	Venereal disease
WD	War Department
WDGS	War Department General Staff
WNRC	Washington National Records Center, NARA
WW II	World War II

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